GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 2, 2023

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

RE: License #: AS370011271
Investigation #: 2023A1029028
Adams Home

Dear Mr. Boyd:

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 (231) 922-5309.

Sincerely,

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
Browningj1@michigan.gov - (989) 444-9614

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AS370011271 |
| | |
| **Investigation #:** | 2023A1029028 |
| | |
| **Complaint Receipt Date:** | 03/07/2023 |
| | |
| **Investigation Initiation Date:** | 03/07/2023 |
| | |
| **Report Due Date:** | 05/06/2023 |
| | |
| **Licensee Name:** | Crisis Center Inc - DBA Listening Ear |
| | |
| **Licensee Address:** | 107 East Illinois, Mt Pleasant, MI 48858 |
| | |
| **Licensee Telephone #:** | (989) 773-6904 |
| | |
| **Administrator:** | Jim Boyd |
| | |
| **Licensee Designee:** | Jim Boyd |
| | |
| **Name of Facility:** | Adams Home |
| | |
| **Facility Address:** | 208 S. Adams Street, Mount Pleasant, MI 48858 |
| | |
| **Facility Telephone #:** | (989) 317-8717 |
| | |
| **Original Issuance Date:** | 03/11/1987 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 10/04/2021 |
| | |
| **Expiration Date:** | 10/03/2023 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>DEVELOPMENTALLY DISABLED<br>MENTALLY ILL |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A did not receive his Haloperidol medication between the dates of February 26- March 4, 2023 because it was not ordered. Also, prior to February 25, 2023 Resident A's afternoon dose of Haloperidol was discontinued, but the medication sheets were not updated and direct care staff member continued to administer this medication. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 03/07/2023 | Special Investigation Intake 2023A1029028 |
| 03/07/2023 | Special Investigation Initiated – Letter to Katie Hohner |
| 03/08/2023 | Contact - Document Received from Katie Hohner ORR |
| 03/14/2023 | Contact - Telephone call received Katie Hohner ORR |
| 03/17/2023 | Contact - Telephone call made to Breanne Hale, Guardian A1 |
| 03/21/2023 | APS Referral made to Centralized Intake |
| 03/22/2023 | Contact - Telephone call made Harmony Cares Medical Group and spoke to Sonya Skacal, medical assistant, also contacted direct care staff members Brandon Garber, Kimberly Jones |
| 03/23/2023 | Inspection Completed On-site - Face to Face with Jim Boyd, Maddie Solmes, Katie Hohner ORR, direct care staff members Ashley Wolfe, Brandon Garber, William Besaw, Brian Recker, Mr. Munez-Fortino, and Resident A at Adams Home |
| 04/19/2023 | Contact – email sent to Jim Boyd |
| 04/20/2023 | Exit conference with Licensee designee Jim Boyd |

**ALLEGATION:**

**Resident A did not receive his Haloperidol medication between the dates of February 26- March 4, 2023 because it was not ordered. Also, prior to February 25, 2023 Resident A's afternoon dose of Haloperidol was discontinued, but the medication sheets were not updated and direct care staff member continued to administer this medication.**

**INVESTIGATION:**

On March 7, 2023, a complaint was received via the Bureau of Community and Health Systems online complaint system with concerns regarding Resident A's medications. According to the complaint information, licensee designee Mr. Boyd reported between the dates of February 26- March 4, 2023 Resident A did not receive Haloperidol due to Assistant Program Director Breanne Hale's not ordering the medication. Additionally, it was reported that prior to February 25, 2023, Resident A's afternoon dose of Haloperidol was discontinued, but Ms. Hale did not update the medication sheets which resulted in staff continuing to dispense this medication. Mr. Boyd was unable to verify how many days Resident A was given the afternoon dose of Haloperidol. According to the complaint, Ms. Hale's employment was terminated effective March 6, 2023 and Resident A's medication is now being administered correctly and the medication sheets were updated. Office of Recipient Rights advisor, Katie Hohner was also assigned to investigate the concerns.

On March 17, 2023, I interviewed former direct care staff member Breanne Hale. She was not aware of any medication changes for Resident A. Ms. Hale stated there were multiple direct care staff that ordered the medications so if anything was out or low, they could call the pharmacy and order it. Ms. Hale stated she was not aware Resident A's afternoon dose of Haloperidol was discontinued before February 2023. Ms. Hale stated she was not aware Resident A did not get the medication between February 26-March 4, 2023. Ms. Hale stated she was the one to update the medication administration records (MAR) if there was a change and she did not recall updating Resident A's MARs.

On March 17, 2023, I contacted Guardian A1. Guardian A1 stated she was not aware of medication changes but this was not something she typically approved she stated. Guardian A1 stated she was not aware of him missing any medications in January or February 2023. Guardian A1 stated she was not notified of any medication errors.

On March 22, 2023, I contacted Harmony Cares Medical Group and spoke to medical assistant, Sonya Skacal. Ms. Skacal stated she does not have anything to do with Resident A's medications because a psychiatrist from Community Mental Health (CMH) prescribes them because Harmony Cares does not have a psychiatrist. Ms. Skacal stated she does not have orders to stop, start, or change the medication. Ms. Skacal stated Resident A had a medication review in January 2023 with Dr. Lyon at CMH. Ms. Skacal stated each time she goes to the home, she also reviews his medications. Ms.

Skacal stated the last order she was aware of was when she visited in January 2023 and reviewed the order from December 27, 2022 which stated take 0.5 tablet Haloperidol once daily, afternoon, and 2 tablets by mouth at bedtime.

On March 22, 2023, I interviewed direct care staff member Brandon Garber. Mr. Garber stated the previous home manager Breanne Hale had the responsibility to update the MAR and order medications. Mr. Garber stated there was an issue refilling Resident A's Haloperidol medication. Mr. Garber stated there was a change in the order because the morning dosage changed but was unaware the afternoon dosage changed because he is typically not working in the afternoon at 2:00 p.m.

On March 22, 2023, I interviewed direct care staff member Kimberly Jones. Ms. Jones stated she did not know there was missed medication until Ms. Hale was terminated. Ms. Jones stated she was not present when the medication was passed at 2:00 p.m. but she heard the medication was administered even after it was discontinued. Ms. Jones stated he did not have his Haloperidol medication to administer to Resident A at the end of February 2023 because it was never ordered. Ms. Jones stated if there are no medications available, she would contact on call to see if they can get it and if she still can't, she would write an *AFC Incident / Accident Report.*

On March 23, 2023, Office of Recipient Rights (ORR) advisor, Katie Hohner and I completed an onsite investigation and met with interim licensee designee Jim Boyd and interviewed direct care staff members at Adams Home. During the onsite investigation, I reviewed Resident A's January, February, and March 2023 MARs. According to the MAR, Resident A was not administered his Haloperidol medication February 26-March 4, 2023. There was also a notation on the back of the February 2023 MAR which stated Resident A did not receive his Haloperidol on February 26, 27, and 28, 2023 because they were "waiting on pharmacy." There was no documentation the previous home manager, Ms. Hale or current direct care staff members had tried to contact the pharmacy to get the Haloperidol delivered to Adams Home.

I reviewed the prescription orders from Dr. Lyon for Resident A's Haloperidol which read as follows:

- December 27, 2022 - Haloperidol 5 MG tablet – Take .5 tablet by mouth once a day, take .5 tablet by mouth daily in the afternoon, and 2 tablets by mouth at bedtime.
- January 12, 2023 - Haloperidol 5 MG tablet – Take .5 tablet by mouth once a day and 2 tablets by mouth at bedtime. *There was no order for an afternoon tablet at that time.* According to the documentation, [Resident A] had a medical review at Community Mental Health for Central Michigan on January 12, 2023 and includes the following statement, *"[Resident A] has tolerated the decrease in Haldol and that will be decreased again today."*
- January 31, 2023 McLaren Mt. Pleasant discharge summary - Haloperidol was 10 mg oral every day at bedtime and 2.5 mg during the day.
- February 18, 2023 - Haloperidol 5 MG tablet – Decrease Haldol 2.5 mg tablet in the AM and 10 mg HS (at bedtime) for psychosis.

- March 10, 2023 - Haloperidol 5 MG tablet – Take .5 tablet by mouth once a day and 2 tablets by mouth at bedtime.

After reviewing the orders, the Haloperidol prescribed in the afternoon was stopped at the January 12, 2023 appointment however according to my review of Resident A's February 2023 MAR, Resident A was still administered the afternoon tablet through the month of February.

Ms. Hohner and I were able to confirm the direct care staff members were now administering the current Haloperidol 5 MG prescription order to take a ½ tablet by mouth once daily and two tablets at bedtime.

Ms. Hohner and I interviewed licensee designee Jim Boyd along with direct care staff member, whose role is the new home manager, Maddie Solmes. Mr. Boyd stated he was informed of the medication errors by Ms. Solmes. Mr. Boyd stated Resident A missed his Haloperidol Feb 26, 27 and 28 in the afternoon but did not miss it at 8 pm. Mr. Boyd stated there were no side effects and nothing was noted of concern from him missing the medications. Mr. Boyd stated the most current prescription is March 1, 2023 and there was a change taking out the afternoon dose of Haloperidol on January 12, 2023, however the MAR was not updated and this medication was still given in error through February 2023 until it was noticed on March 4, 2023.

On March 23, 2023, I interviewed direct care staff member, Ashley Wolfe. Ms. Wolfe stated on February 26, 27, 28, Haloperidol was not passed to Resident A because the medication was not in the home. Ms. Wolfe stated she contacted the pharmacy on February 22, 2023 because she knew the medication is getting low so she could get them filled before it ran out and told them they were out of the medication and the pharmacy told her they would contact Resident A's doctor. Ms. Wolfe stated she called back each day and there were no updates. Ms. Wolfe stated she contacted Resident A's doctor as well but stated she did not know if she had any documentation about calling the pharmacy or doctor. Ms. Wolfe stated she worked on February 26 and 27 but she did not pass a medication that day and did not recall if she wrote an *AFC Incident / Accident Report*.

Ms. Wolfe stated there was a change in the Haloperidol script but she did not know Resident A's medication order changed during January 2023 because no one knew that it had changed because they were using the old package which said to give the Haloperidol three times per day. Ms. Wolfe stated the updated order was not in the MAR.

On March 23, 2023 I interviewed direct care staff member William Besaw at Adams Home. Mr. Besaw stated until recently Resident A was receiving three doses per day because he was following the instructions on the medications and on the orders he was given. Mr. Besaw stated they would check the medication orders and always pass medications with a second person. Mr. Besaw stated normally he would have been passing the morning dose on the weekends and the 2 pm dose during the week and on

Saturdays. Mr. Besaw stated he did not notice that anything was wrong because he compared what was on the package to the instructions written in the MAR. Mr. Besaw stated he did notice they ran out of Haloperidol in February 2023 because their procedure is to take a red pen and circle, write on the back of the MAR, and contact Downtown Drugs. Mr. Besaw stated he thought he would have written a couple *AFC Incident / Accident Report* for the days in February and Ms. Hale would have sent the *AFC Incident / Accident Report.*

On March 23, 2023 I interviewed direct care staff member, whose current role is assistant home manager, Brian Recker at Adams Home. Mr. Recker stated if a resident runs out of a medication, the direct care staff member writes on the back of the medication sheet and contacts the pharmacy for a refill. Mr. Recker stated he thought he wrote an *AFC Incident / Accident Report* but could not be sure that far back but he knows that is policy. Mr. Recker stated on January 12, 2023, Resident A went to an appointment at CMH but he was not aware the afternoon dose was discontinued because this was not communicated. Mr. Recker reviewed the 5 R's of passing medications and stated he did all of these when he passed the medications in January 2023. Mr. Recker stated there was a lack of communication between Ms. Hale and the staff members making sure these changes were communicated and the MAR was updated.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14312** | **Resident medications.** |
| | **(2) Medication shall be given, taken, or applied pursuant to label instructions.** |
| **ANALYSIS:** | Resident A's Haloperidol was not ordered timely and the facility did not have the medication to administer for the dates of February 26-March 4, 2023. There was also a notation on the back of the February 2023 MAR that Resident A did not receive his Haloperidol because they were "waiting on pharmacy."<br><br>I reviewed the prescription orders from Dr. Lyon for Resident A's Haloperidol which changed on January 12, 2023 - Haloperidol 5 MG tablet – Take .5 tablet by mouth once a day and 2 tablets by mouth at bedtime. According to the review of Resident A's resident record, there was no order for an afternoon tablet at that time however the MAR was not changed and the afternoon medication was still given at 2:00 p.m. until it was noticed on March 4, 2023. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

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

Jennifer Browning _____4/20/2023_____
Licensing Consultant Date

Approved By:

05/02/2023

_____

Dawn N. Timm Date
Area Manager