GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 22, 2023

Janet Difazio
Spectrum Community Services
185 E. Main St
Suite 700
Benton Harbor, MI 49022

RE: License #: AS630397223
Investigation #: 2023A0991020
Groveland Home

Dear Ms. Difazio:

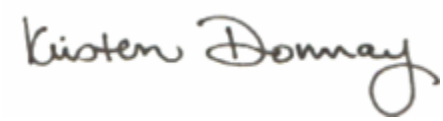
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AS630397223
Investigation #:	2023A0991020
Complaint Receipt Date:	04/25/2023
Investigation Initiation Date:	04/25/2023
Report Due Date:	06/24/2023
Licensee Name:	Spectrum Community Services
Licensee Address:	185 E. Main St Suite 700 Benton Harbor, MI 49022
Licensee Telephone #:	(734) 458-8729
Licensee Designee:	Janet Difazio
Name of Facility:	Groveland Home
Facility Address:	9921 Walnut Hill Drive Davisburg, MI 48350
Facility Telephone #:	(248) 634-1297
Original Issuance Date:	06/06/2019
License Status:	REGULAR
Effective Date:	12/06/2021
Expiration Date:	12/05/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Per incident report, Resident J's 8:00pm medications from 04/22/23 were found on his dresser with a cup of applesauce on the morning of 04/23/23.	Yes

III. METHODOLOGY

04/25/2023	Special Investigation Intake 2023A0991020
04/25/2023	Special Investigation Initiated - Telephone Call to Office of Recipient Rights (ORR) worker, Katie Garcia
04/25/2023	Referral - Recipient Rights Received from recipient rights
04/25/2023	APS Referral Adult Protective Services (APS) referred to Centralized Intake, denied.
04/26/2023	Inspection Completed On-site Unannounced onsite inspection
04/26/2023	Contact - Document Received Medication administration record, health care chronological, staff schedule
04/27/2023	Contact - Telephone call made To direct care worker, Makiah Moore
04/27/2023	Contact - Telephone call made To direct care worker, Gail Dake
05/02/2023	Contact - Telephone call made Left message for direct care worker, Nakia Coffee
05/04/2023	Contact - Telephone call made To direct care worker, Nakia Coffee
05/22/2023	Exit Conference Via telephone with licensee designee, Janet DiFazio

ALLEGATION:

Per incident report, Resident J's 8:00pm medications from 04/22/23 were found on his dresser with a cup of applesauce on the morning of 04/23/23.

INVESTIGATION:

On 04/25/23, I received an incident report from Groveland Home which indicated that on 04/23/23, direct care worker, Nakia Coffee was getting Resident J up for the day when she noticed a cup with applesauce and medications on his dresser. It was determined that they were Resident J's 8:00pm medications from 04/22/23, which were not administered. I created a special investigation intake, which was assigned to me for investigation. I initiated my investigation on 04/25/23 by contacting the assigned Office of Recipient Rights (ORR) worker, Katie Garcia, and by making a referral to Adult Protective Services (APS) Centralized Intake. APS denied the complaint for investigation.

On 04/26/23, I conducted an unannounced onsite inspection at Groveland Home. I interviewed the home manager, Sandy Bradley. Ms. Bradley stated that direct care workers, Gail Dake and Makiah Moore, were working during the evening on 04/22/23. Ms. Dake was changing Resident J in his bedroom, and Ms. Moore was passing medications. Ms. Moore had Resident J's medications prepared and brought them into his bedroom. She set the medications on the dresser while she helped Ms. Dake change Resident J, but then she forgot to pass the medication. Staff, Nakia Coffee, noticed the medications on Resident J's dresser the following morning. They contacted Resident J's primary care physician. The patient coordinator stated that if there were any issues the doctor would reach out, but they did not hear back from the doctor. Resident J did not have any negative side effects from the missed medications, and he received his morning medications as prescribed. Ms. Bradley stated that there were no issues with any of the other residents' medications. Ms. Moore did initial Resident J's medication administration record (MAR) to indicate medications were passed on 04/22/23, even though they were not given to Resident J. Ms. Bradley stated that Ms. Moore has been taken off medication passing for 30 days. She stated that Ms. Moore was new to medication passing and had only been administering medications for about a month. They have also implemented a new policy at Groveland Home that medications should not be administered in the residents' bedrooms. Staff will only pass medications at the medication cart. Ms. Bradley stated that previously, it was common to pass Resident J his medications in his bedroom. They would sit him up in bed and give him his medications.

During the onsite inspection, I observed Resident J in his bedroom watching TV. I attempted to interview Resident J; however, he did not wish to engage in conversation and would not answer any questions.

During the onsite inspection, I reviewed a copy of Resident J's April MAR. The MAR was initialed for 8:00pm medications on 04/22/23; however, the following medications were not administered:

- Calcium 500mg Tab (Oyst shell)
- Cetirizine 10mg Tab (Zyrtec)
- Divalproex Tab 500mg ER (Depakote)
- Docusate 100mg CAP (Colace)
- Eliquis Tab 2.5mg
- Furosemide Tab 40mg (Lasix)
- Lacosamide Tab 200mg (Vimpat)
- Levetiracetam Tab 250mg (Keppra)
- Simvastatin Tab 20mg (Zocor)
- Tamsulosin Cap 0.4mg (Flomax)

I reviewed a copy of Resident J's Health Care Chronological (HCC) which notes that the midnight staff found Resident J's 8:00pm medications from 04/22/23 in a cup of applesauce on his dresser. The HCC notes that Ms. Bradley completed an incident report, contacted the physician, and left a message for Resident J's guardian. She also disposed of the medications. I reviewed a copy of the training verification form for Makiah Moore, which shows she completed medication training through Easter Seals on 03/25/23. I reviewed the medications and medication administration records for the residents in the home. I did not observe any other discrepancies.

On 04/27/23, I interviewed direct care worker, Makiah Moore, via telephone. Ms. Moore stated that she has been working at Groveland Home since September 2022. She is fully trained and completed medication training. Ms. Moore stated that they were having a hectic evening on 04/22/23. They had taken the residents on an outing, and she was trying to pass medications before her shift ended at 8:00pm. She stated that they use an electronic medication administration record. She scanned Resident J's bubble packs into the computer, which checks them off on the electronic MAR. She then pressed the next button to finalize the medication pass and initial the MAR before she took the medications into Resident J's bedroom. Ms. Moore stated that Ms. Dake was changing Resident J and they needed to apply cream to his bottom, so she set his other medications on the tall dresser in Resident J's bedroom and assisted Ms. Dake. After they changed Resident J and applied his creams, Ms. Moore left the room. Her shift ended at 8:00pm, and it did not register that she had not administered Resident J's oral medications. She stated that it just slipped her mind. Ms. Moore stated that Resident J did not have any negative side effects from the missed medications.

On 04/27/23, I interviewed direct care worker, Gail Dake, via telephone. Ms. Dake stated that she has worked at Groveland Home for nearly 30 years. She stated that on 04/22/23, she was changing Resident J because he had a bowel movement. Ms. Dake stated that Ms. Moore came into Resident J's bedroom with his medications, and she asked her to help clean up Resident J, as he can be difficult to change. Ms. Moore set down the medications and then forgot to pass them. Ms. Dake stated that they did apply

Resident J's creams, but he did not get his oral medications. Ms. Dake stated that her shift ended at midnight. She was checking on Resident J every 30 minutes, but she did not notice his medications on his dresser. Ms. Dake stated that it is typical for Resident J to get his medications in his bedroom, as his bed can sit up. Resident J did not have any negative side effects from missing his medications.

On 05/04/23, I interviewed direct care worker, Nakia Coffee, via telephone. Ms. Coffee stated that she has worked at Groveland Home since February 2023. Ms. Coffee stated that she was working from 12:00am-8:00am on 04/23/23. She went to get Resident J up in the morning and saw a cup of applesauce with his medications on his dresser. She stated that she took a picture and sent it to her manager. Ms. Coffee stated that she had not noticed the medications while doing bed checks throughout the night, as they were sitting on his dresser by the closet. She did not know who was passing medications the night before. Ms. Coffee stated that she does not pass medications, as she is not fully medication trained yet. She stated that she has observed staff passing Resident J his medications in his bedroom, as his bed sits up. Ms. Coffee did not have any concerns about the care of the residents in the home. She was not aware of Resident J having any negative side effects from the missed medications.

On 05/22/23, I conducted an exit conference via telephone with licensee designee, Janet DiFazio. Ms. DiFazio stated that she would submit a corrective action plan to address the violations in the report and would conduct an in-service training with staff to review medication passing procedures. She stated that direct care worker, Makiah Moore, is no longer working in the home.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on the information gathered during my investigation, there is sufficient information to conclude that Resident J did not receive his 8:00pm medications as prescribed on 04/22/23. Direct care worker, Makiah Moore, set the medications on Resident J's dresser while she helped another staff change Resident J. Ms. Moore forgot to administer the medications, which were found on the dresser by midnight staff the following morning. Resident J did not receive his 8:00pm dose of Calcium 500mg Tab, Cetirizine 10mg Tab, Divalproex Tab 500mg ER, Docusate 100mg CAP, Eliquis Tab 2.5mg, Furosemide Tab 40mg, Lacosamide Tab 200mg, Levetiracetam Tab 250mg, Simvastatin Tab 20mg, or Tamsulosin Cap 0.4mg.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 of the following provisions: (b) Complete an individual medication log that contains all of the following information: (v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that staff, Makiah Moore, initialed Resident J's April 2023 medication administration record for the 8:00pm medications on 04/22/23 indicating that the medications were given, but Resident J did not receive his 8:00pm dose of Calcium 500mg Tab, Cetirizine 10mg Tab, Divalproex Tab 500mg ER, Docusate 100mg CAP, Eliquis Tab 2.5mg, Furosemide Tab 40mg, Lacosamide Tab 200mg, Levetiracetam Tab 250mg, Simvastatin Tab 20mg, or Tamsulosin Cap 0.4mg
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.

05/22/23

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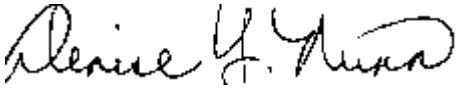
Kristen Donnay Date
Licensing Consultant

Approved By:



05/22/2023

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Denise Y. Nunn Date
Area Manager