GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 6, 2023

Maribeth Leonard
Jackson-Hillsdale CMH Board LifeWays
1200 N. West Avenue
Jackson, MI 49202

RE: License #: AS380407018
Investigation #: 2023A0007015
LifeWays Crisis Residential

Dear Ms. Leonard:

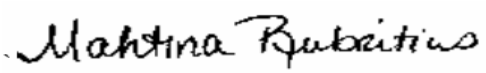
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (313) 456-0380.

Sincerely,



Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. #9-100
Detroit, MI 48202
(517) 262-8604
(517) 763-0211

Enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS380407018
Investigation #:	2023A0007015
Complaint Receipt Date:	04/13/2023
Investigation Initiation Date:	04/13/2023
Report Due Date:	06/12/2023
Licensee Name:	Jackson-Hillsdale CMH Board LifeWays
Licensee Address:	1200 N. West Avenue Jackson, MI 49202
Licensee Telephone #:	(517) 789-1209
Administrator:	Maribeth Leonard
Licensee Designee:	Maribeth Leonard
Name of Facility:	LifeWays Crisis Residential
Facility Address:	1200 N. West Avenue Jackson, MI 49202
Facility Telephone #:	(517) 789-1209
Original Issuance Date:	08/11/2021
License Status:	REGULAR
Effective Date:	02/11/2022
Expiration Date:	02/10/2024
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED

	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Allegations that on 4/12/2023, Resident A did not receive her medications as prescribed.	Yes
Allegations of additional medication errors.	Yes

III. METHODOLOGY

04/13/2023	Special Investigation Intake - 2023A0007015
04/13/2023	Special Investigation Initiated - Letter
04/13/2023	APS Referral
04/20/2023	Inspection Completed On-site - Unannounced - Face to face contact with Mr. David Sprunger, Administrator, Mr. Stitt, Director of Crisis Services, Mr. Lowe, Ms. Tucelli, and Resident B.
05/11/2023	Contact - Telephone call received from Employee #2. Interview.
05/24/2023	Contact - Telephone call received - Message from (previous) Employee #2.
05/24/2023	Contact - Telephone call made - Follow-up interview with Employee #2.
06/01/2023	Contact - Telephone call made - Interview with Resident A.
06/01/2023	Contact - Telephone call made to Employee #1, no answer.
06/05/2023	Contact - Telephone call made to Resident F. Interview.
06/05/2023	Contact - Telephone call made to Mr. Sprunger, no answer.
06/05/2023	Contact - Document Sent - Email sent to Administrative Staff. I requested the contact information for Employee #4.
06/05/2023	Contact - Telephone call made to Employee #4 x 2. Message left.

06/05/2023	Contact - Document Sent - Email to ORR Officer #1.
06/05/2023	Contact - Telephone call made to ORR Officer #1. Discussion.
06/05/2023	Contact - Telephone call received from Employee #4. Interview.
06/05/2023	Contact - Document Received - Copies of ORR Reports.
06/05/2023	APS Referral
06/06/2023	Exit Conference conducted with Ms. Marybeth Leonard, Licensee Designee.

ALLEGATIONS:

- **Allegations that on 4/12/2023, Resident A did not receive her medications as prescribed.**

- **Allegations of additional medication errors.**

INVESTIGATION:

Allegations that on 4/12/2023, Resident A did not receive her medications as prescribed.

As a part of this investigation, I reviewed the incident report signed by Mr. Sprunger, Program Manager, (Administrator) and the following was documented:

> On April 12, 2023, "during CRU RN's daily review of EMAR, it was discovered that six medications were not administered last night for this consumer [Resident A]." Omeprazole, Pregabalin, Trazodone, Topamax, and steroid cream were not marked as given on the EMAR. CRU RN obtained a new prescription for Pregabalin yesterday from the pharmacy. CRU Nurse witnessed the last dose from previous bottle be administered yesterday at 2:00 p.m. The new bottle had not been opened this morning when CRU Nurse witnessed medication pass. CRU Nurse spoke with the consumer and asked if she took all her nighttime medications." The consumer stated "they didn't look right, but I didn't want to doubt anyone. I know I didn't get my blue one." The "CRU Program Manager contacted DCW that administered evening medications on 4/12/23 who stated she administered all the consumer's medications last night. DCW stated she used the touch screen to administer medication and that it may not have been saved for some reason for some of the medications and DCW apologized for that."

On April 20, 2023, I conducted an unannounced on-site investigation and made face to face contact with Mr. David Sprunger, Administrator, Mr. Stitt, Director of Crisis Services, Mr. Lowe, and Ms. Tucelli.

Regarding Resident A, Mr. Sprunger stated that the consumer said she only missed one medication and Nurse A was able to confirm this information. The corrective action would include a written warning to Employee #1 and the next step would be termination.

The facility staff provided me with a copy of the medication log for Resident A. It reflected that the 8:00 p.m. medications had not been marked as passed, as there was a gray X in the boxes instead of a green check mark for the Omeprazole, Pregabalin, Trazodone and Topamax.

While I was at Lifeways conducting the investigation, I was informed of an additional medication error that occurred yesterday, on April 19, 2023. This information will be addressed later in the report.

On June 1, 2023, I interviewed Resident A, and she recalled that staff forgot to give her a medication. She informed me that it could have been more than one medication missed, but she specifically noted the one medication for her heartburn was not given. She confirmed that it was a blue pill that she did not receive. I inquired if she had any adverse side effects from missing her medications and she stated that her heartburn was not controlled as normal, and she woke up with anxiety. However, she didn't know if the anxiety was because she had heartburn. Resident A informed me that the facility staff caught the medication error right away, as the next morning, they asked her about the medications she received. She stated that they (Lifeways staff) have also followed up with her twice since this incident occurred.

Allegations of additional medication errors.

While I was at Lifeways conducting the investigation, I was informed of an additional medication error that occurred yesterday, on April 19, 2023. Resident B was given Resident C's medications. Employee #2 thought he missed a dosage of medication and readministered the med (giving two pills since he also missed one at 5:00 p.m.). Resident C had gone to the hospital for an unrelated medical issue.

I inquired if there were any adverse effects, and administrative staff informed there was no need for medical attention. Nurse B was notified about the medication error at 3:00 a.m., Doctor #1, and poison control were also contacted.

They also notified Resident B of what occurred, and he took it well. Resident B reported to have a headache but he's also a coffee drinker. Staff were instructed to monitor him closely for the duration of his stay, and informed that he could have

Tylenol if needed. He could not have ibuprofen, as it could interact with the medications he was given.

The administrative staff reported to be concerned about the medication errors. Mr. Lowe reported that they attempted to work with Employee #2 but they're moving forward with termination. According to Mr. Stitt, they would be interviewing for a night supervisor, and they would like to have 24-hour crisis supervision, onsite, at all times.

I requested that they forward me copies of the incident reports regarding this situation along with the medication logs.

While at the facility, I interviewed Resident B. Resident B informed me that there was a medication error and that "they could get into big trouble." Resident B informed me that he previously worked in an adult foster care home. I inquired if he had any side effects after receiving another resident's medications and he stated, "I'm fine." Resident B reported to be groggy and that he tried to sleep it off. Resident B informed me that when he woke up, he knew he wasn't supposed to take the medications. Resident B stated, "as long as the young lady doesn't lose her job, I'm not trying to sue."

I asked what happened, and Resident B stated that staff (Employee #2) said, "you missed your 5:00 p.m. medication." Resident B stated that she (Employee #2) didn't ask his name or birthdate and handed him the meds. It was two pills. Resident B stated, "I don't take these, but maybe I do." He went on to say, "I just said fuck it, excuse me, and I just took it." Resident B stated there was a possibility that he could have missed his medications because he was in transit part of the day.

I made face to face contact with Mr. Stitt, Director of Crisis Services, who informed that he was not happy about the situation and that he would fix the problem.

As a part of this investigation, I reviewed the incident reports.

> It was noted that on April 19, 2023, at 4:45 p.m., Resident C was transported to the hospital as he was complaining of right flank pain, having diarrhea and vomiting. He was admitted into the hospital at 10:00 p.m.
>
> On another incident report, dated April 20, 2023, it was noted that Nurse B received a call from Employee #2 on April 20, 2023, at 2:41 a.m. Employee #2 stated that she had given Resident C's medication (Eliquis 5mg x2) to another consumer in the home by mistake and signed out the medication in Resident C's EMAR. This consumer (Resident C) was actually at the hospital in the emergency department.

The actions taken by staff included Nurse B immediately contacting Mr. Sprunger, Program Manager, notifying Doctor #1 at 3:00 a.m., and notifying the on-call nurse supervisor.

The corrective measures included interviewing for an onsite overnight supervisor, following the disciplinary process, and retraining staff for medication administration.

Regarding Resident B, it was noted on an incident report that Nurse B received a call from Employee #2 on April 20, 2023, at 2:41 a.m. Employee #2 stated “I’m so sorry, you’re going to kill me. I accidentally gave the new guy someone else’s medications.” Employee #2 stated “I gave him the guy’s medications that was sent to the hospital earlier.”

The actions taken by staff included Nurse B immediately contacting Mr. Sprunger, Program Manager, notifying Doctor #1 at 3:00 a.m., contacting poison control, and notifying the on-call nurse supervisor.

The corrective measures included interviewing for an onsite overnight supervisor, following the disciplinary process, and retraining staff for medication administration.

It should be noted that a previous investigation was conducted regarding medication errors (SIR# 2023A0007018). During that investigation, a review of Employee #2’s file reflected that she successfully completed the Medication Administration training on November 15, 2022.

On May 11, 2023, I interviewed Employee #2. Employee #2 confirmed that she did give a resident the wrong medications. She also voiced her concerns regarding her previous employment. She stated that she has a low IQ and ADHD, and that she was upfront with management regarding this matter. Employee #2 stated she was told not worry about it because she would not be working alone; however, she did work alone. Employee #2 stated that she loved her job and she’s really hurt (about their decision to terminate her).

On June 1, 2023, I spoke with (previous) Employee #2 again. She stated that she spoke to Employee #3 at shift change. At shift change, the worker arriving is given a shift note of all the residents that are present. According to Employee #2, Resident C, Resident D, and Resident E were listed as present in the facility; however, Resident C was not actually present because he was still at the hospital. Originally, Resident B’s name was not on the list.

According to Employee #2, Resident B was in a private room on a teleconference with a doctor when she went in to administer his medications. She told the resident her name and that she was there to pass his medications. She also asked him to state his name and date of birth, which was stated to her. Employee #2 stated that

some people go by different names or maybe that was his middle name. Employee #2 gave him the medications. She also recalled that Resident B was wearing a tether.

Later that day, Mr. Sprunger called Employee #2 and asked if she could bag up all Resident C's belongings because he was not returning to the facility. She then realized that she had given Resident C's medications to Resident B. Once she realized what occurred, she contacted Nurse B and informed her of the error. According to Employee #2, Nurse B said everything should be fine.

Employee #2 stated that she was called in and fired without them even hearing her side of the story. She stated that it should have been revealed at the beginning of the shift that Resident C was not present in the home, instead of him being listed as being there. In addition, that when she told management about the list, she was told she had to get rid of it. She added Resident B's name to the list, only after she discovered the error, and that Resident C was not returning from the hospital.

Employee #2 stated that she later spoke to Nurse B, who informed her that Resident B knew he did not have medications prescribed to him.

Employee #2 also stated that they did not retrain the other staff for medication errors until after she got fired. She did not understand why she could not have another chance when other individuals, including the program manager, had a medication error and was demoted, but not terminated.

Employee #2 stated that she took full accountability for the medication error, and she checked on Resident B several times, ensuring that he was okay. She stated that Resident B would reply "I'm good." Employee #2 stated that Resident B also told her that he understood that she made a mistake and never intended for that to happen. Employee #2 stated that she was a hard worker, and worked when others did not, and she could not understand why she didn't get another chance.

During the course this investigation, I reviewed another incident report, dated April 25, 2023, and the following was noted:

> On April 24, 2023, at about 8:10 p.m., Employee #4 administered the evening medication dosage of Cymbalta to Resident F one day sooner than it was supposed to be administered. The prescription order for the Cymbalta was written 1 Tab daily x 4 days, then 1 Tab twice daily (the 4/24/2023 a.m. dose was the last of the once daily dosing). It was documented that the program manager monitored a medication pass and asked Employee #4 what she checks when passing medications. Employee #4 reported she checks the individual's name on the MAR and medication, medication name, dosage, time, and route. Employee #4 asked Resident F her name and date of birth when she came to the door for her medication to confirm it was the right individual. After completing the medication pass for other residents, the program manager asked Employee #4 if

she documented the medication pass for Resident F. Employee #4 checked and that is when she noticed that the Cymbalta was not supposed to start twice daily until 4/25/2023. The corrective measures included retraining Employee #4 to pass medications and following disciplinary procedures.

On June 5, 2023, I interviewed Resident F. Resident F stated she had some concerns about her stay at the facility, as she was not the only person who had a medication error during that time. She could not specifically recall their names, but she stated two other residents had medication errors and that the staff person got fired. Resident F stated that when the staff member gave her the medications, she asked her (staff/name unknown) if she (staff) was sure that those were the medications that she (Resident F) was supposed to get. The staff member (name unknown) told Resident F that was the medication that was in her file. Resident F stated that she and other residents were sleeping a lot, which was not normal for her. I inquired if she knew the medications she was given and she stated she did not. Resident F stated that she met with a community worker (name unknown) who told her that her case was closed at Lifeways and that she could not return. Resident F stated that she spoke to her case manager and doctor because she wanted additional services to address her mental health.

On June 5, 2023, I spoke with ORR Officer #1. I inquired if they investigated the medication errors that had occurred at the facility. She informed me that they had investigated the complaints regarding Resident A, Resident B, and Resident F, the allegations were substantiated, and corrective action plans have been submitted. She agreed to send me copies of the investigations.

On June 6, 2023, I interviewed Employee #4. Employee #4 stated this was her first night working the night shift and she was doing a medication pass 8:00 p.m. with her supervisor. After she passed the medication and checked the information, she noticed that the bubble packed medication was for the next night. Employee #4 stated the supervisor wrote down the information about the mistake. Employee #4 stated she noticed that she made the mistake that night. Employee #4 reported to be fully trained, she has passed medications for over five years, and she had no other medication errors. After this incident, she had to be retrained to pass medications.

On June 6, 2023, I conducted the exit conference with Ms. Marybeth Leonard, Licensee Designee. I informed her of the findings and recommendations. She reported to have knowledge of the challenges and medication errors, and recent investigations conducted by ORR. She agreed to submit a written corrective action plan to address the established violations.

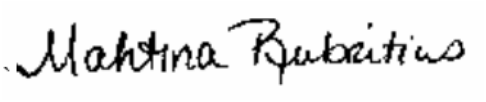
APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	**Regarding Resident A:** Mr. Sprunger documented the medication errors on the incident report. He also documented that he contacted the DCW that administered evening medications on 4/12/23. She stated she administered all the consumer's medications last night. In addition, that she used the touch screen to administer medications, and that it may not have been saved for some reason for some of the medications. Employee #1 apologized for that. The facility staff provided me with a copy of the medication log for Resident A. It reflected that the 8:00 p.m. medications had not been marked as passed, as there was a gray X in the boxes instead of a green check mark for the Omeprazole, Pregabalin, Trazodone and Topamax. According to Mr. Sprunger, the consumer said she only missed one medication and Nurse A was able to confirm this information. Resident A informed me that it could have been more than one medication missed, but she specifically noted the one medication for her heartburn was not given. Based on the information gathered during this investigation and provided above, it's concluded that on April 12, 2023, Resident A did not receive her medication as prescribed. **Regarding Resident B:** Resident B was given Resident C's medications. Resident B stated that staff (Employee #2) said, "you missed your 5:00 p.m. medication." Resident B stated that she (Employee #2) didn't ask his name or birthdate and handed him the meds. It was two pills. Resident B took the medication. When I inquired if he had any side effects after receiving another resident's medications and he (Resident B) stated, "I'm fine." Resident B reported to be groggy and that he tried to sleep it off. Employee #2 stated that she took full accountability for the medication error, and she checked on Resident B several times, ensuring that he was okay. She stated that Resident B would reply "I'm good." Employee #2 stated that Resident B also told her that he understood that she made a mistake and never intended for that to happen.

	Based on the information gathered during this investigation and provided above, it's concluded that there is a preponderance of the evidence to support the allegations that Resident C's medications were not administered as prescribed. Resident B received Resident C's medications. **Regarding Resident F:** Mr. Sprunger documented on an incident report that Employee #4 administered the evening medication dosage of Cymbalta to Resident F one day sooner than it was supposed to be administered. Resident F stated she had some concerns about her stay at the facility, as she was not the only person who had a medication error during that time. After Employee #4 passed the medication and checked the information, she noticed that the bubble packed medication was for the next night. ORR Officer #1 informed me that they had investigated the complaints regarding Resident A, Resident B, and Resident F, the allegations were substantiated, and corrective action plans have been submitted. Based on the information gathered during this investigation and provided above, it's concluded that there is a preponderance of the evidence to support the allegations that Resident F's medications were not administered as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED** This is a **REPEAT VIOLATION.** Please see SIR # 2023A0007010 for additional information.

IV. RECOMMENDATION

Contingent upon receipt of a detailed and acceptable written corrective action plan, it's recommended that the status of the license remains unchanged.



6/6/2023

Mahtina Rubritius — Date
Licensing Consultant

Approved By:

6/6/2023

Ardra Hunter — Date
Area Manager