GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 9, 2023

Alica Wrzesinski
56345 CR. 384
GRAND JUNCTION, MI 49056

RE: License #: AS800409323
Investigation #: 2023A1031040
Wrzesinski Specialized AFC

Dear Alica Wrzesinski:

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 (616) 356-0183.

Sincerely,
Kristy Duda, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AS800409323
Investigation #:	2023A1031040
Complaint Receipt Date:	05/15/2023
Investigation Initiation Date:	05/15/2023
Report Due Date:	07/14/2023
Licensee Name:	Alica Wrzesinski
Licensee Address:	56345 CR. 384 GRAND JUNCTION, MI 49056
Licensee Telephone #:	(269) 767-4972
Licensee Designee/Administrator:	Alica Wrzesinski
Name of Facility:	Wrzesinski Specialized AFC
Facility Address:	05838 56th St. Grand Junction, MI 49056
Facility Telephone #:	(269) 767-0393
Original Issuance Date:	09/14/2021
License Status:	REGULAR
Effective Date:	03/14/2022
Expiration Date:	03/13/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A consumed Resident B’s medications that were not secured.	Yes
Additional Findings	No

III. METHODOLOGY

05/15/2023	Special Investigation Intake 2023A1031040
05/15/2023	Special Investigation Initiated - Letter Documents requested from Licensee Alica Wrzesinski.
05/15/2023	Contact – Document Received and Reviewed.
05/24/2023	Inspection Completed On-site
05/24/2023	Contact - Face to Face Interview with Skylar Connick and Resident A.
06/09/2023	Exit Conference held with Licensee Alica Wrzesinski.

ALLEGATION:

Resident A consumed Resident B’s medications that were not secured.

INVESTIGATION:

On 5/15/23, I received an incident report dated 5/12/23 that was completed by Skylar Connick. The incident report indicates that staff had a restroom emergency and secured medications out of sight behind a computer while residents were in their bedrooms. It was assumed that Resident A came into the kitchen while staff was in the bathroom and took another resident’s medications thinking it was candy. Resident A had an empty medication cup and stated “candy” when staff came back into the kitchen. Staff contacted the supervisor and poison control per company policy. Poison control stated Resident A would be fine and to monitor for grogginess and give fluids as much as possible. Staff also contacted a physician and they stated Resident A would be tired but should be okay and to monitor her. Corrective

measures indicated included staff being retrained on safety and medication processes.

On 5/15/23, I sent an email to licensee Alica Wrzesinski requesting Resident A's medication list. Mrs. Wrzesinski reported the home contacted poison control and an after-hours physician and they stated Resident A would be groggy and would not need to go to the emergency room. Mrs. Wrzesinski reported Resident A took five medications that belonged to another resident.

On 5/15/23, I reviewed the medication lists for Resident A and Resident B. Resident A consumed Resident B's Divalproex Sodium Dr 250mg, Haloperidol 2mg, Hydroxyzine HCL 10mg, Lithium Carbonate 450mg ER 450mg, and Metformin HCL 500mg.

On 5/24/23, I interviewed direct care worker Sylar Connick in the home. Ms. Connick reported she had a personal restroom emergency, and she hid Resident B's medication cup behind the computer so she could run to the bathroom. Ms. Connick reported the medications were not secured. Ms. Connick reported all the residents were in their bedrooms and did not think the residents would gain access to the medications. Ms. Connick reported when she came out of the bathroom Resident A had an empty medication cup in her hand and said "candy". Ms. Connick reported she immediately contacted Poison Control and they advised her that Resident A would be sleepy and to monitor her. Ms. Connick reported Mrs. Wrzesinski immediately retrained her on how to properly secure medications and to pass medications. Ms. Connick reported she has learned from her mistake and knows that she should have put the medication in the secured medication room prior to using the restroom.

On 5/24/23, I observed Resident A in the home. Resident A was not able to engage in the interview process due to being nonverbal.

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:	Ms. Connick admitted to not properly securing medications in the home which resulted in Resident A consuming another residents medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

6/1/23

Kristy Duda
Licensing Consultant

Date

Approved By:

6/9/23

Russell B. Misiak
Area Manager

Date