GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 30, 2023

Karmen Ball
Hernandez Home LLC
P.O. Box 277
Bloomingdale, MI 49026

RE: License #: AS800316739
Investigation #: 2023A1031039
Baseline Home

Dear Ms. Ball:

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 #:	AS800316739
Investigation #:	2023A1031039
Complaint Receipt Date:	05/15/2023
Investigation Initiation Date:	05/15/2023
Report Due Date:	07/14/2023
Licensee Name:	Hernandez Home LLC
Licensee Address:	44409 Baseline Road Bloomingdale, MI 49026
Licensee Telephone #:	(269) 521-4130
Administrator:	Karmen Ball
Name of Facility:	Baseline Home
Facility Address:	44409 Baseline Road Bloomingdale, MI 49026
Facility Telephone #:	(269) 521-4130
Original Issuance Date:	04/23/2012
License Status:	REGULAR
Effective Date:	10/23/2022
Expiration Date:	10/22/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was given the wrong medications.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/15/2023	Special Investigation Intake 2023A1031039
05/15/2023	Special Investigation Initiated - Letter Documents requested from licensee Karmen Ball.
05/18/2023	Contact - Document Requested.
05/24/2023	Inspection Completed On-site
05/24/2023	Contact - Face to Face Interview with Staff #1.
06/01/2023	Contact - Telephone Interviews with Robert Cox and Hillary Mahone.
06/01/2023	Contact – Telephone Call to Kaylee Marlow.
06/06/2023	Contact – Telephone Call to Kaylee Marlow.
06/06/2023	Contact - Telephone Interview with Kaitlyn Galvan.
06/26/2023	Contact – Telephone Call to Kaylee Marlow.
06/30/2023	Exit Conference held with Licensee Designee Karmen Ball.

ALLEGATION:

Resident A was given the wrong medications.

INVESTIGATION:

On 5/15/23, I receive an incident report completed by direct care worker (DCW) Lea Torres dated 5/11/23 that read Resident A received another resident's medications. DCW Kaylie Marlow popped the medications and gave them to Ms. Torres to pass.

The home manager and 911 was contacted. Resident A was taken to the hospital and medically cleared to return home with staff. The corrected measures taken included staff not passing medications until retaking a medication class. A staff meeting was held on 5/12/23 to discuss the correct was to pass medications.

On 5/18/23, I reviewed the medication administration record (MAR) for Resident A. The MAR read that on 5/11/23 DCW Kaylee Marlow prepped and administered Resident A's evening medications.

On 5/24/23, I interviewed Staff #1 in the home. Staff #1 reported DCW Lea Torres is no longer working at the home. Staff #1 reported they did not have any information regarding the incident involving Resident A receiving the wrong medications. Staff #1 reported she has not observed staff prepping medications for other staff to pass.

On 6/1/23, I interviewed DCW Robert Cox via telephone. Mr. Cox reported he did not have any information related to the allegations. Mr. Cox reported he never prepares medications for multiple residents and does not provide medication to other staff to pass.

On 6/1/23, I interviewed the director of medical Hillary Mahone via telephone. Ms. Mahone reported Ms. Marlow reported to her that she prepped Resident A's medication and gave the medication to Ms. Torres to pass.

On 6/1, 6/6, and 6/26, I attempted to interview Ms. Marlow via telephone and was unsuccessful. As of 6/26/23, I have not received a telephone call back from Ms. Marlow.

On 6/26/23, I referenced the licensing file and reviewed SIR #2023A1031017 dated 4/13/23. The home received a licensing violation due to staff improperly documenting a resident's MAR.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on interviews and the review of documentation, the home did not provide Resident A with his medications pursuant to label instructions as he received another resident's medications.
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:	The MAR for Resident A read that Ms. Marlow prepped and administered Resident A's medication. The MAR was not properly documented to reflect the correct initials for the person who administered the medication which shall be entered at the time the medication is given. The incident report reflects that Ms. Torres passed Resident A's medications although she did not prepare and complete his MAR.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2023A1031017 dated 4/13/23 and CAP dated 5/8/23.**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 5/18/23, I requested and reviewed the home's training curriculum requested from licensee designee Karmen Ball. The medication training the home provided meets the basic requirements of medication training required per licensing rules.

Staff #1 reported they believe the medication training provided "could be better". Staff #1 reported they feel the training needs to be more detailed and believes the training has not been beneficial for new staff. Staff #1 reported staff need more hands-on training in the home, and they need to be shadowed for a longer period of time to ensure they are comfortable passing medications independently. Staff #1 reported new staff are currently required to pass medications a total of three times by themselves while being shadowed before they can pass medications on their own.

Mr. Cox reported the initial medication training he received was informative. Mr. Cox reported the trainer went through a computer training and provided some hand-on training during the class to show them how to prepare medications. Mr. Cox reported

there needs to be improvement to the training received in the home. Mr. Cox reported he feels more hands-on training would be beneficial once they begin working in the home. Mr. Cox reported he was required to pass medications three times while being shadowed and then was expected to pass medications on his own. Mr. Cox reported he believes the hands-on training should be longer or until a worker reports they are comfortable passing medications independently. Mr. Cox reported he worked in multiple homes managed by Cornerstone and the way medications are passed in each home is inconsistent. Mr. Cox reported he previously passed medications to the wrong individual due to the minimal training he received. Mr. Cox reported he received hands on training from the current home manager and it was very beneficial. Mr. Cox reported he was shown in-depth how to navigate the medication system, MAR, and narcotic counts. Mr. Cox reported this individual training he received from the manager was the most beneficial training he received.

Ms. Mahone reported she became aware of medication errors happening in some homes operated by Cornerstone and recognized a need for a change in training. Ms. Mahone reported she previously conducted medication training and the home has since hired a new trainer. Ms. Mahone reported staff have informed her that the new trainer was boring. Ms. Mahone reported she will be taking over teaching the medication trainings and engage the new trainer. Ms. Mahone reported she has been conducting 1:1 medication training with staff that have had medication errors. Ms. Mahone reported the home is in the process of implementing a new in-home training and staff will be shadowed in the home by the medication trainer.

Ms. Galvan reported the initial medication training she received was self-explanatory. Ms. Galvan reported she felt there should have been more training provided in the home once she started passing medications. Ms. Galvan reported workers should be shadowed while they pass medications until they are comfortable to do it alone. Ms. Galvan reported the new home manager retrained her and it was very beneficial.

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: **(a) Be trained in the proper handling and administration of medication.**

ANALYSIS:	Based on interviews held with staff, it has been determined that staff are not receiving adequate training for the proper handling and administering of medications once they begin working in the home. Staff reported the initial classroom training was helpful but would benefit more from a hands-on training when directly working in the home and handling medications. Staff have reported they do not feel that passing medications three times prepares them for passing medications independently. While the medication administration curriculum staff review in a classroom setting provides a basis of safe administration, there appears to be inadequate amount of observation and supervised task completion of the new worker by an experienced senior staff person that ensures competency in the task before then new worker works alone.
CONCLUSION:	**VIOLATION ESTABLISHED**

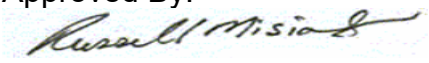
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that there be no change in the status of the license.

6/27/23

Kristy Duda — Date
Licensing Consultant

Approved By:



6/27/23

Russell B. Misiak — Date
Area Manager