GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 27, 2023

Megan Fry
MCAP DeWitt Opco, LLC
Suite 115
21800 Haggerty Road
Northville, MI 48167

RE: License #: AM190404598
Investigation #: 2023A0466055
Serene Gardens of DeWitt 1

Dear Ms. Fry:

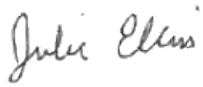
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (517) 284-9727.

Sincerely,



Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM190404598
Investigation #:	2023A0466055
Complaint Receipt Date:	08/04/2023
Investigation Initiation Date:	08/07/2023
Report Due Date:	10/03/2023
Licensee Name:	MCAP DeWitt Opco, LLC
Licensee Address:	Suite 115 21800 Haggerty Road Northville, MI 48167
Licensee Telephone #:	(517) 484-6980
Administrator:	Megan Fry
Licensee Designee:	Megan Fry
Name of Facility:	Serene Gardens of DeWitt 1
Facility Address:	1177 Solon Road DeWitt, MI 48820
Facility Telephone #:	(517) 484-6980
Original Issuance Date:	11/02/2020
License Status:	REGULAR
Effective Date:	05/02/2023
Expiration Date:	05/01/2025
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS

	AGED

II. ALLEGATION

	Violation Established?
Resident A was administered Resident B's medications.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/04/2023	Special Investigation Intake-2023A0466055.
08/04/2023	Contact - Document Received- assigned licensing consultant Leslie Herrguth.
08/04/2023	APS Referral-Tom Hilla Assigned.
08/07/2023	Special Investigation Initiated - Telephone APS Tom Hilla.
08/07/2023	Contact - Document Received Tom Hilla.
08/14/2023	Inspection Completed On-site.
08/15/2023	Contact - Document Sent EMS records requested/received.
08/15/2023	Contact - Document Sent email to Kelly McCann.
08/15/2023	Contact - Telephone call made DCW Damaris Young interviewed.
08/15/2023	Contact - Telephone call made DCW Angeline Zuehlke interviewed.
8/16/2023	Contact - Document Sent email to Kelly McCann.
09/25/2023	Contact - Document Sent email to Kelly McCann.
09/25/2023	Contact - Document Sent/received to/from APS Tom Hilla.
09/26/2023	Exit Conference with licensee designee Megan Fry, message left.

ALLEGATION: Resident A was administered Resident B's medications.

INVESTIGATION:
On 08/04/2023, Complainant reported that Resident A is 79 years, lives in an assisted living home and is diagnosed with dementia. Complainant reported that on 8/2/2023 Resident A was brought to Sparrow ED from Serene Gardens of Dewitt because Resident A was given another resident's medication in addition to her own prescribed medication. Complainant reported it was unknown which direct care staff member administered the medication or how the wrong medication was administered to Resident A. Complainant reported Resident A experienced symptoms of headache, dizziness and low blood pressure after receiving both her prescribed medications as well as another resident's medications. Complainant reported that Resident A was stable, alert and oriented in the ED.

On 08/04/2023, I interviewed assigned licensing consultant Leslie Herrguth who reported that she spoke to adult protective services (APS) specialist Tom Hilla who reported direct care worker (DCW) Angie Zuehlke was training Damaris Young, a newly hired direct care worker, who had not been trained to administer medication yet. Licensing consultant Herrguth reported DCW Zuehlke needed to toilet another resident and directed DCW Young, the untrained staff member to administer medication. Licensing consultant Leslie Herrguth reported DCW Young administered Resident A her medication as well as Resident B's medication. Licensing consultant Herrguth reported APS Hilla said he would be substantiating neglect of Resident A.

On 08/04/2023, I interviewed APS Hilla who reported that on 08/02/2023, DCW Zuehlke was training DCW Young in medication administration since she had not yet been trained nor was she competent to administer medication independently yet. APS Hilla reported DCW Zuehlke went to toilet another resident and directed DCW Young, the untrained staff member, to administer Resident A her medications. APS Hilla reported DCW Young administered Resident A her medications and Resident B's medications to Resident A.

On 08/14/2023, I conducted an unannounced investigation and I interviewed Kelly McCann executive director who reported that the facility currently has a COVID-19 outbreak therefore I did not attempt to interviewed Resident A. Ms. McCann reported that on 08/02/2023, DCW Zuehlke was training DCW Young on medication administration. Ms. McCann admitted that DCW Young, who was not trained/competent in medication administration, passed Resident B's medications to Resident A on 08/02/2023. Ms. McCann reported this resulted in Resident A going to the emergency room on 08/02/2023 per the direction of the facility physician because she did ingest both her prescribed medications and the prescribed medications for Resident B. Ms. McCann reported that in the future, a DCW being trained in medication administration will be trained by management instead of by a DCW that is also working the floor. Ms. McCann reported DCW Zuehlke nor DCW

Young were on shift at the time of the unannounced investigation therefore they were not available to interviewed.

I reviewed an *Incident/Accident Report* dated 08/02/2023 at 10am which was completed by DCW Zuehlke and signed by Ms. McCann. In the “explain what happened” section of the report it stated, “Dee was training to med tech, I was overseeing her she gave right meds to wrong person.” “In the action taken by staff” section of the report it stated, “B/P called 911.” In the “corrective measures" section of the report it stated, “Staff will go through all med tech classes first, then training with management for first day.”

I reviewed Resident A’s August *Medication Administration Record* (MAR) and under the “Pass Notes” it stated, 08/02/2023 7:49 am, morning meds for [Resident B] were given, PCP notified.”

I reviewed DCW Zuehlke’s employee record which documented that she was hired on 03/05/2004 and she was medication trained on 09/01/2014.

On 08/15/2023, I reviewed the *Lansing Mercy Ambulance Service Report* dated 08/02/2023 at 15:34 regarding Resident A. In the “chief complaint” section of the report it stated, “Patient was given another patients medication and now having a reaction.” In the “primary system” section of the report it stated, “altered mental state.” In the “narrative” section of the report it stated, “EMS arrives to find patient on couch in her room alert. Patient has history of dementia but was able to hold a conversation with EMS and follow commands. Patient stated that she understands that she was given the wrong medications and needs to go to the ER. Patient stated that she was a little lightheaded, very tired, has a headache denies any pain. Note patient was given all of her own medications on top of the other patients’ medications. Facility doctor was on scene with patient, handed a list of medications and stated his biggest concern were Lasix and two medications that are classified as antihistamines.”

On 08/15/2023, I interviewed DCW Young by phone. DCW Young reported that her first day was 07/31/2023. DCW Young reported that she worked three days in a row training. DCW Young reported that on 08/02/2023, DCW Zuehlke was the only DCW on duty for 12 residents. DCW Young reported this was her first day passing medications in this building but she had been training in other buildings since her date of hire. DCW Young reported that she did not know these residents by face or name. DCW Young reported that she took Resident B’s medications out of the bubble pack while DCW Zuehlke watched. DCW Young reported she was feeling comfortable and DCW Zuehlke told her to take the medication in the medication cup to Resident B. DCW Young reported she asked DCW Zuehlke where Resident B’s room was as she was unfamiliar and DCW Zuehlke pointed to the bedroom so she took the medications there. DCW Young reported DCW Zuehlke stayed by the medication cart while she took the medications to the resident. DCW Young reported DCW Zuehlke did not go into the residents room with her while she

administered the medication. DCW Young reported that when she entered the room she asked the resident if she was Resident B and she said yes. DCW Young reported this resident took all the medications but when she went to give the insulin shot the resident reported that she does not get shots and that is when she thought that she may have given the medications to wrong resident. DCW Young asked the resident her name again and she said her name was, "[Resident A]." DCW Young went to find DCW Zuehlke and tell her what happened. DCW Young reported that when she showed her which room she went into DCW Zuehlke told her that was not Resident B's room. DCW Young reported there was a miscommunication about which room she was supposed to take the medications. DCW Young reported she was not completely trained/competent in medication administration but she thought she was doing what was part of the training process. DCW Young reported that DCW Zuehlke called the facility nurse to report what had occurred. DCW Young reported being instructed to take Resident A's vitals every 30 minutes. DCW Young reported that initially Resident A was conscious but later reported feeling tired and was observed to have an unsteady gait and low energy which was not her baseline. DCW Young reported DCW Zuehlke was handling everything pertaining to the medication error including writing the *Incident/Accident Report*.

I interviewed DCW Zuehlke who reported that on 08/02/2023 she was training DCW Young on medication administration. DCW Zuehlke reported that DCW Young was "doing so well I was only watching her once in a while because I had to walk away to help the residents." DCW Zuehlke reported that this is a memory care facility. DCW Zuehlke confirmed DCW Young asked her where Resident B's room was and DCW Zuehlke reported she pointed to the room behind the kitchen and not down the hallway where DCW Young took the medication. DCW Zuehlke confirmed the miscommunication about the location of Resident B's resident bedroom. DCW Zuehlke reported she contacted the facility nurse who came to assess Resident A and she was instructed to take Resident A's vitals every 30 minutes which she did. DCW Zuehkle reported Ms. McCann also came to assess Resident A. DCW Zuehlke reported that before she left work for the day, Resident A's blood pressure was stable for several hours and that she was talking and acting normal. DCW Zuehlke reported that later that day under the direction of the facility physician who came to see Resident A, EMS was contacted for further evaluation.

On 09/25/2023, APS Hilla stated he would be substantiating neglect of Resident A by both DCW Zuehlke and DCW Young for the medication error occurring.

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

ANALYSIS:	APS Hilla, Ms. McCann, DCW Zuehlke and DCW Young all reported that DCW Young administered Resident A, Resident B's medication. The *Lansing Mercy Ambulance Service Report* dated 08/02/2023 at 15:34 stated in the "chief complaint" section of the report it stated, "Patient was given another patients medication and now having a reaction." Resident A was given another resident's medications which were not prescribed to her causing the need for emergency medical evaluation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

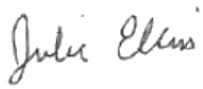
INVESTIGATION:
On 08/14/2023, I conducted an unannounced investigation and I interviewed Ms. McCann who reported DCW Young who was not trained/competent in medication administration when she passed medications to Resident A on 08/02/2023.

On 08/15/2023, DCW Zuehlke and DCW Young both reported DCW Young was not fully trained/competent in medication administration and when she passed medications to Resident A on 08/02/2023. DCW Zuehlke and DCW Young reported DCW Young independently administered medications to Resident A which resulted in Resident A receiving her own medication as well as another resident's medications. DCW Zuehlke and DCW Young reported DCW Zuehlke did not go with DCW Young to supervise her while she administered medication to Resident A.

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:	Ms. McCann, DCW Zuehlke and DCW Young all reported DCW Young was not fully trained/competent in medication administration when she passed medications to Resident A resulting in a medication error.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan I recommend no change in license status.



09/26/2023

Julie Elkins Date
Licensing Consultant

Approved By:

09/27/2023

Dawn N. Timm Date
Area Manager