GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 2, 2023

James Boyd
Crisis Center Inc - DBA Listening Ear
PO Box 800
Mt Pleasant, MI 48804-0800

RE: License #: AS370011271
Investigation #: 2023A1029056
Adams Home

Dear Mr. Boyd:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On September 19, 2023, you submitted an acceptable written corrective action plan and verification of compliance for the staff in-service, however, please send verification of Ms. Solmes medication refresher training by October 6, 2023.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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 (231) 922-5309.

Sincerely,

Jennifer Browning

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
Browningj1@michigan.gov - (989) 444-9614

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AS370011271 |
| | |
| **Investigation #:** | 2023A1029056 |
| | |
| **Complaint Receipt Date:** | 08/24/2023 |
| | |
| **Investigation Initiation Date:** | 08/24/2023 |
| | |
| **Report Due Date:** | 10/23/2023 |
| | |
| **Licensee Name:** | Crisis Center Inc - DBA Listening Ear |
| | |
| **Licensee Address:** | 107 East Illinois, Mt Pleasant, MI 48858 |
| | |
| **Licensee Telephone #:** | (989) 773-6904 |
| | |
| **Administrator:** | James Boyd |
| | |
| **Licensee Designee:** | James Boyd |
| | |
| **Name of Facility:** | Adams Home |
| | |
| **Facility Address:** | 208 S. Adams Street, Mount Pleasant, MI 48858 |
| | |
| **Facility Telephone #:** | (989) 317-8717 |
| | |
| **Original Issuance Date:** | 03/11/1987 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 10/04/2021 |
| | |
| **Expiration Date:** | 10/03/2023 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>DEVELOPMENTALLY DISABLED<br>MENTALLY ILL |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| On August 21, 2023, direct care staff member Ashley Wolfe administered another resident's medications to Resident A causing his blood pressure to raise. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 08/24/2023 | Special Investigation Intake 2023A1029056 |
| 08/24/2023 | Special Investigation Initiated – Letter with Jim Boyd |
| 08/29/2023 | Inspection Completed On-site – ORR Katie Hohner and I met with licensee designee Jim Boyd, and direct care staff members Maddie Solmes, Victoria Vanderbrook, Ashley Wolfe at Adams Home. |
| 09/11/2023 | Inspection Completed On-site – Jim Boyd and Maddie Solmes at Adams Home for renewal inspection. |
| 09/12/2023 | APS Referral - Made APS referral to Centralized Intake |
| 09/19/2023 | Contact - Document Sent - Jim Boyd sent Corrective Action Plan. |
| 09/19/2023 | Exit Conference with licensee designee Jim Boyd. |

**ALLEGATION: On August 21, 2023, direct care staff member Ashley Wolfe administered another resident's medications to Resident A causing his blood pressure to raise.**

**INVESTIGATION:**

On August 24, 2023, a complaint was received via the Bureau of Community and Health Systems online complaint system alleging Resident A received the wrong medication (Midodrine 5 mg dose-2 tablets) leading to his blood pressure increasing. According to the complaint, Office of Recipient Rights (ORR) advisor, Katie Hohner is also investigating the concerns.

On August 29, 2023, ORR Ms. Hohner and I interviewed direct care staff member Ashley Wolfe at Adams Home. Ms. Wolfe stated she administered the medications incorrectly to Resident A on August 21, 2023. Ms. Wolfe stated she was preparing the medications and when she passed Resident B's medications, she was distracted by

another direct care staff member Maddie Solmes preparing the Boost with the thickening powder for another resident. Ms. Wolfe stated she was distracted and administered Resident B's medications to Resident A. Ms. Wolfe stated it was confusing because there were two people preparing medications in the same space. Ms. Wolfe stated after she administered the medication to Resident A, she followed the protocol needed because she called the pharmacist at Downtown Drugs who told her to take the blood pressure every fifteen minutes to see if it was elevated. Ms. Wolfe stated when she took Resident A's blood pressure, it was raising so he was taken to the hospital. Ms. Wolfe stated Resident A received a medication to lower his blood pressure, he was monitored at the hospital, and then she brought him home.

Ms. Wolfe stated the procedure is to prepare the medications in the office and then take them to the resident. Ms. Wolfe stated since she did Resident B's medications first, she thought she already gave them to Resident B, but instead gave them to Resident A in error. Ms. Wolfe stated part of the procedure is to tell the residents what they are taking but she did not tell Resident A what he was taking at the time and admitted she was not following the 5 Rights.

On August 29, 2023, ORR Ms. Hohner and I interviewed licensee designee, Jim Boyd. Mr. Boyd stated Ms. Wolfe has been employed at Adams Home for a couple years and there have not been concerns related to administering medications in the past. Ms. Boyd was able to show training records indicating Ms. Wolfe completed her initial medication training on December 19, 2021 and a medication refresher training on May 16, 2023. Ms. Solmes completed training on December 22, 2021 which gave instructions on "*Medication Orientation for 2nd Med Checker*." Ms. Hohner stated she also completed a Rights Refresher in June 2023 regarding medication policies and Ms. Solmes and Ms. Wolfe were in attendance.

On August 29, 2023, ORR Katie Hohner and I interviewed direct care staff member whose current role is home manager, Madeline Solmes at Adams Home. Ms. Solmes stated she had prepared Resident B's medication and his BOOST drink on August 21, 2023. Ms. Solmes stated by the time she looked up from what she was doing, Ms. Wolfe was letting her know she gave Resident A the medication prepared for Resident B. Ms. Solmes stated she asked Ms. Wolfe if Resident A still had them in his mouth and he did not. Ms. Solmes stated she contacted Downtown Drugs and the pharmacist stated the Midodrine 5 mg dose (2 tablets) was considered a low dose of blood pressure medications. Ms. Solmes stated the pharmacist instructed her to take his blood pressure every 15 minutes which made Resident A upset so it was raising each time they would check his blood pressure. Ms. Solmes stated Resident A was taken to the hospital where they gave him medication to lower his blood pressure. Ms. Solmes stated she was the 2nd medication checker but stated she does not always follow the direct care staff member administering the medications and they do not watch the person swallow their medications. Ms. Solmes clarified the "2nd medication checker" does not check the whole medication pass or tell residents what medications they are taking. Ms. Hohner advised her all these steps should be done going forward to reduce further medication errors.

On August 29, 2023, ORR Katie Hohner and I interviewed direct care staff member Victoria Vanderbrook. Ms. Vanderbrook stated she was cleaning the kitchen at the time of the error. Ms. Vanderbrook stated she realized something was wrong because she noticed Ms. Holmes was upset because Ms. Wolfe administered the wrong medication. Ms. Holmes told her Resident A received Resident B's medication. Ms. Vanderbrook stated she has also completed medication administration training including notifying residents what medications are being administered and when she is the 2nd medication checker, she will follow the first person so she can watch the whole medication pass.

During the on-site investigation, I reviewed the *Discharge Summary and Instructions* from McLaren Central Michigan Emergency Department for Resident A's visit on August 21, 2023, which listed the reason for visit *as "medical problem-minor; Wrong medication given. Given blood pressure medication Midodrine. Final Diagnosis: Accidental medication error.* I reviewed Resident A's medication administration record (MAR) and confirmed Resident A was not prescribed Midodrine.

I reviewed *Community Mental Health for Central Michigan physician's orders for AFC and Specialized Contract Providers*:

> *"Question or problems for physician: [Resident A was given 10 mg Midodrine at 1:34 p.m. and he's not prescribed Midodrine. Last BP was 159/95. He gets Metoprolol 25 mg ER and Lisinopril 20 mg in the AM. His last dose was at 7:41 a.m.*
>
> *Completed by the physician: Labs look good. BP medication given. No adverse reaction to medication given. Last BP 133/91. Monitor BP and return if over 105 or symptoms of chest pain or change in behavior. Check BP every hour."*

On September 11, 2023, I completed an on-site inspection for the licensing renewal at Adams Home and met with Mr. Boyd. Mr. Boyd stated he has continued to train the direct care staff members at Adams Home regarding medication administration and will be holding an in-service with direct care staff members regarding the importance of having a second person reviewing medication administration and reviewing the protocol on September 12, 2023. Mr. Boyd stated Ms. Solmes is schedule to complete medication refresher on Improving MI Practices by October 3, 2023. Mr. Boyd stated Ms. Wolfe is no longer an employee at Adams Home.

Special Investigation Report # 2023A1029028 dated May 2, 2023 cited Rule 400.14312 (2) because a resident did not receive his Haloperidol between February 26-March 4, 2023 because it was not ordered from the pharmacy. The same resident was also receiving the wrong dosage of Haloperidol because the MAR was not changed to reflect the afternoon dose was discontinued and it was given in error from January 12-March 4, 2023. A Corrective Action Plan was signed on May 8, 2023 indicating the following corrections would be made:

*"All direct care staff members are to review in-services on "What to do if Meds are Running Low" and "Transcribing medication changes" from Listening Ear's Medication policy.*

*All direct care staff members are responsible for communicating effectively any changes occurring after a doctor appointment, including an AFC Incident / Accident Report if needed.*

*All direct care staff members review the log and medication book at the start of their shift so they are aware of changes.*

*Program director to check weekly that documentation is correct and matches any med changes that may have occurred.*

*Director of Residential Services to review monthly."*

To document compliance with the Corrective Action Plan, Licensee designee Mr. Boyd submitted training in-service signed verifications for all direct care staff member regarding What to do after a doctor appointment and if meds are running low, transcribing medication changes, and documentation of discontinued meds from Listening Ear.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14312** | **Resident medications.** |
| | **(2) Medication shall be given, taken, or applied pursuant to label instructions.** |
| **ANALYSIS:** | Direct care staff member administered Midodrine to Resident A which is not prescribed on August 21, 2023. Ms. Wolfe stated she did this because she was distracted by Ms. Solmes preparing BOOST in the same room. Ms. Wolfe stated she did not follow the 5 Rights when administering Resident A's medications. Licensee designee Mr. Boyd completed a Corrective Action Plan on September 19, 2023 and has retrained the direct care staff members at Adams Home regarding the *Two Person Medication Passing Protocol* and has Ms. Solmes scheduled for a medication refresher training on October 3, 2023. |
| **CONCLUSION:** | **REPEAT VIOLATION ESTABLISHED [SIR# 2023A1029028 DATED MAY 2, 2023. CAP COMPLETED.]** |

## IV. RECOMMENDATION

An approved corrective action plan has been received; therefore, I recommend no change in the license status.

Jennifer Browning 09/22/2023
Jennifer Browning Date
Licensing Consultant

Approved By:

10/03/2023

Dawn N. Timm Date
Area Manager