STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 13, 2023

Timothy Bertram
Frances Specialized Residential, LLC
2304 W. Frances Rd.
Mt. Morris, MI 48458

RE: License #: AM250411036
Investigation #: 2023A0779058
Frances Specialized Residential

Dear Timothy Bertram:

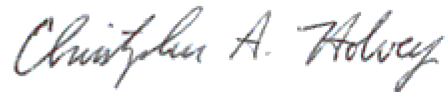
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 643-7960.

Sincerely,



Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM250411036
Investigation #:	2023A0779058
Complaint Receipt Date:	08/07/2023
Investigation Initiation Date:	08/07/2023
Report Due Date:	10/06/2023
Licensee Name:	Frances Specialized Residential, LLC
Licensee Address:	2304 W. Frances Rd. Mt. Morris, MI 48458
Licensee Telephone #:	(248) 705-9802
Administrator:	Timothy Bertram
Licensee Designee:	Timothy Bertram
Name of Facility:	Frances Specialized Residential
Facility Address:	2304 W. Frances Rd. Mt. Morris, MI 48458
Facility Telephone #:	(248) 705-9802
Original Issuance Date:	03/31/2022
License **Status:**	REGULAR
Effective Date:	09/30/2022
Expiration Date:	09/29/2024
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff Mekiyah Wingard gave Resident A the wrong dosage of morphine on 8/3/23.	Yes

III. METHODOLOGY

08/07/2023	Special Investigation Intake 2023A0779058
08/07/2023	APS Referral Complaint was referred to APS centralized intake.
08/07/2023	Special Investigation Initiated - Telephone Spoke to complainant.
08/10/2023	Inspection Completed On-site
08/11/2023	Contact - Telephone call made Spoke to staff person, Mekiyah Wingard.
08/17/2023	Contact - Telephone call made Spoke to Hospice nurse.
08/21/2023	Exit Conference Held with licensee designee, Timothy Bertram.

ALLEGATION:

Staff Mekiyah Wingard gave Resident A the wrong dosage of morphine on 8/3/23.

INVESTIGATION:

On 8/7/23, a phone conversation took place with Complainant, who stated that staff person, Mekiyah Wingard has admitted to giving Resident A the wrong dose of his Morphine medication. Complainant state that staff Wingard could not get the syringe used to measure the medication to work properly, so staff Wingard used a medication cup to measure the medication and gave Resident A an extreme amount of Morphine. Complainant reported that staff at this home said that Resident A was clearly under the influence but had no other ill effects from the increased dose of Morphine. Complainant

stated that the next morning home manager, She'quilla Williams, figured out what happened and called Hospice to report the incident.

On 8/10/23, an on-site inspection was conducted, and Resident A was interviewed. Resident A stated that he does not know how much Morphine he was given on 8/3/23 and that he just takes what meds the staff give him. Resident A reported that the amount of Morphine he was given affected him for a long time, but nothing else happened as a result and that he is doing okay now. Resident A stated that he likes living at this house.

On 8/10/23, home manager, She'quilla Williams, stated that Hospice had just prescribed Resident A the Morphine and that the dose that Resident A received during 2nd shift on 8/3/23 was his first dose of the medication. Manager Williams stated that when she came to work the morning of 8/4/23, Resident A looked and was acting like he was still intoxicated and that is when she realized that staff Wingard had given Resident A the wrong dose of Morphine. Manager Williams reported that she called Hospice, who stated to just keep an eye on Resident A. Manager Williams stated that a Hospice nurse then came to the home and prefilled multiple syringes with the correct dose of morphine for future use.

On 8/11/23, a phone interview was conducted with staff person, Mekiyah Wingard, who stated that on 8/3/23, Resident A was complaining of having pain and asked for some Morphine. Staff Wingard stated that she could not get the measuring syringe that came with the Morphine medication to work, so she used a small med cup and filled it to the line labeled (5) on the cup and gave that to Resident A. Staff Wingard reported that the 5ml listed on the prescription was the actual strength of the medication, not the dose amount. Staff Wingard claims that other than clearly being under the influence of Morphine, Resident A seemed to be okay the rest of her shift and was still awake when she left at 10:00pm.

The physician order/script for Resident A's Morphine medication was reviewed. The order was written for 100mg/5ml Morphine Concentrate oral solution. The script stated to take ¼ ml by mouth every hour as needed for pain. Resident A's medication administration record (MAR) was also reviewed and confirmed that Resident A received a dose of Morphine during the evening of 8/3/23. There were no other issues noted regarding the review of the MAR.

On 8/17/23, a phone conversation took place with Hospice nurse, Tyler Goodrich, who stated that the home notified them of the medication error on 8/4/23. Nurse Goodrich stated that there was nothing to do but provide Resident A with oxygen if needed and watch him closely. Nurse Goodrich reported that it took a few days for the Morphine to completely wear off, but that Resident A seems to have had no ill effects of the increased dose and seems to be doing okay. Nurse Goodrich stated that with the measuring syringe not working correctly and the use of the med cup, he could see where the mistake could have easily happened. Nurse Goodrich stated that the home now has prefilled syringes of the Morphine to prevent any dosing errors in the future.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Staff person, Mekiyah Wingard, stated that the measuring syringe that came with the Morphine was not working properly, so she used a med cup to measure out Resident A's liquid Morphine. Staff Wingard admits that she gave Resident A the wrong dose of Morphine. It was confirmed that staff Wingard gave Resident A 5ml of Morphine instead of the prescribed ¼ ml.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 8/21/23, an exit conference was held with licensee designee, Timothy Bertram. Licensee Bertram was informed of the outcome of the investigation and that a written corrective action plan was required.

IV. RECOMMENDATION

Upon receipt of an approved written corrective action plan, it is recommended that the status of this home's license remain unchanged.

9/12/2023

Christopher Holvey Date
Licensing Consultant

Approved By:

9/13/2023

Mary E. Holton Date
Area Manager