GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 31, 2023

James Pilot
Bay Human Services, Inc.
P O Box 741
Standish, MI 48658

RE: License #: AS520281606
Investigation #: 2023A0873015
Lakeside

Dear Mr. Pilot:

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,

Garrett Peters, Licensing Consultant
Bureau of Community and Health Systems
234 W. Baraga Ave.
Marquette, MI 49855
(906) 250-9318

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS520281606
Investigation #:	2023A0873015
Complaint Receipt Date:	07/06/2023
Investigation Initiation Date:	07/06/2023
Report Due Date:	09/04/2023
Licensee Name:	Bay Human Services, Inc.
Licensee Address:	PO Box 741 3463 Deep River Rd Standish, MI 48658
Licensee Telephone #:	(989) 846-9631
Administrator:	Tammy Unger
Licensee Designee:	James Pilot
Name of Facility:	Lakeside
Facility Address:	49 Airfield Road Gwinn, MI 49841-9097
Facility Telephone #:	(906) 346-6235
Original Issuance Date:	05/05/2006
License Status:	REGULAR
Effective Date:	11/27/2022
Expiration Date:	11/26/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was not administered his PRN as documented.	Yes
Additional Findings	No

III. METHODOLOGY

07/06/2023	Special Investigation Intake 2023A0873015
07/06/2023	Special Investigation Initiated - On Site
07/06/2023	Contact - Face to Face Interviews with staff
07/07/2023	APS Referral Referred to APS
07/13/2023	Contact - Face to Face Interview with Marcia Rogers
07/13/2023	Contact - Face to Face Interview with Resident A
07/13/2023	Contact - Telephone call made Interview with Dr. George Krzymowski
07/13/2023	Contact - Telephone call made Call to Amy Manning, caseworker
07/13/2023	Contact - Telephone call made Call to Jessie Wright, nursing supervisor, left voicemail

07/13/2023	Contact - Telephone call made Call to guardian, no answer
08/04/2023	Contact - Document Received Received Resident A MAR
08/21/2023	Contact - Document Received Received copy of Bay Human Services med passing policy
08/21/2023	Contact - Telephone call received Interview with Faye Witte to discuss results of rights investigation
08/30/2023	Contact – Face to Face Interview with Kaitlyn Koval at Lakeside
08/30/2023	Contact – Documents received Received copies of IRs for the dates in question
08/31/2023	Exit Conference With Tammy Unger, administrator

ALLEGATION: Resident A was not administered his PRN as documented.

INVESTIGATION: On 7/5/23 I received a voicemail from Faye Witte, Pathways CMH recipient rights officer, detailing an investigation she had initiated due to medication-related issues with Resident A. According to the voicemail, and a follow-up email, Faye Witte explained that in late April of this year, Resident A was given 4 doses of Lorazepam (Ativan), as a PRN, over the course of three days. On April 23rd Resident A was given two doses, one at 10:15am and another at 2:50pm. On April 24th Resident A was given one dose at 9:30am. On April 25th Resident A was given one dose at 8:24am. However, on April 26th, Resident A went to the hospital to have his blood drawn, and the results showed no trace of Lorazepam. A recipient rights investigation was initiated after a complaint due to concerns about Resident A possibly not receiving his medications, contrary to the home's documentation.

On 7/6/23 I conducted an unannounced onsite inspection of the home and met with Faye Witte, Pathways CMH recipient rights officer (RRO) and Jessica Lindgren, Bay

Human Services Regional Manager, to conduct interviews with staff. While there I noticed that other residents were happy, clean, and well taken care of. In the interview regional manager Lindgren explained that Resident A was currently staying at UPHS psych ward, having recently had an episode in which the police were involved, and Resident A was taken to the hospital. Regional Manager Lindgren informed me that she believed the home is doing everything correctly but doesn't understand why there would be no Lorazepam in Resident's A's blood. Lindgren also told me that when it was decided a blood test would be performed, the only staff member at the home that knew when it was to occur was the home manager, Kaitlyn Koval.

Also, on 7/6/23, before we conducted staff interviews, I reviewed Resident A's medication administration record (MAR). The MAR confirms that on the three days leading up to his blood test, Resident A was administered 4 doses of Lorazepam, 1mg. The MAR details that Resident A is allowed this medication at this dose as a PRN up to three times per day for "severe agitation or distress." The MAR, and associated incident reports, indicate that on April 23rd Resident A was given two doses of Lorazepam, one at 10:15am and another at 2:50pm. On April 24th Resident A was given one dose at 9:30am. On April 25th Resident A was given one dose at 8:24am. The MAR and included medical notes indicate that these 4 doses of Lorazepam were given as a PRN to Resident A for agitation and physical aggression. The incident reports go into more detail about the reasons for the PRN, including Resident A yelling and pacing around the home while raising his fists, showing high anxiety, and displaying physical aggression upon staff members. In each incident Resident A's guardian was called to approve the passing of the PRN and Resident A was given a 1mg dose.

On 7/6/23, I was able to review Resident A's blood test from the hospital. The test shows that Resident A's blood sample was collected from him on 4/26/23 at 11:02am. It was received and entered by the lab on 4/27/23 and the results were reported on 5/04/23. The blood test showed negative for Lorazepam.

On 7/6/23, I interviewed Jennifer DeForge, direct care staff. Staff DeForge reported that she had been working at the home since around mid-February and has been trained to pass meds since the end of March. Staff DeForge was present when the PRN was passed to Resident A on two occasions within the 3 days in question: April 23rd and April 25th. Staff DeForge reported that on the 23rd she had called direct care staff Brittany Snay to come to the home as Resident A's behavior had escalated to the point that he was anxious and showing repetitive behaviors. Staff DeForge reported that she had never passed the PRN to Resident A but had seen other staff do so. Staff DeForge also reported that the PRN sometimes had the intended effect of calming Resident A, but often it would not, and Resident A's behaviors would continue. When this occurs, other staff are often called to the home. Staff DeForge reported that everyone in the home wants to see Resident A get better and she has never witnessed nor heard of any staff taking meds from the home.

On 7/6/23, I interviewed Rebecca Jeske, direct care staff. Staff Jeske reported that she has been working for Bay Human Services for about 15 years and has been at Lakeside for about a year. Staff Jeske was present for the passing of the PRN on April 25th. She reported that Resident A was given the PRN that day at around 8:45am although she doesn't remember it affecting his behavior. Staff Jeske also reported that although she doesn't believe any direct care staff would purposely not give Resident A his PRN, it is not always practical to watch a resident take their medications. Staff Jeske reported that Resident A would usually get worked up in the mornings and would often have to be given a PRN before 10am. In her experience, Resident A would often not be affected by the PRN.

On 7/6/23, I interviewed home manager (HM) Kaitlyn Koval. HM Koval reported Pathways had reached out to her to tell her about their concerns with the potential of Resident A not receiving his Lorazepam as a urine test had recently tested negative for the drug. HM Koval believes there is "no chance" Resident A would not take his medication when given and reports the meds are given to residents in a clear cup with other staff around and observing. She does not believe a staff member would not give Resident A his PRN as staff want Resident A to remain calm throughout the day. HM Koval reported that she does not have any concerns about the home's staff taking or not passing meds to residents.

On 7/6/23, I interviewed Brittany Snay, direct care staff. Staff Snay reported she has worked for Bay Human Services for about 1 year and is trained in passing PRNs to residents. Staff Snay reported that when Lorazepam was given to Resident A, sometimes it would help calm his behaviors and sometimes it would not. Staff Snay was the staff member that passed the PRN to Resident A on April 24th when she passed it with HM Koval present. Staff Snay reported that Resident A was never one to not take his medications as Resident A is known to have a condition known as polydipsia, in which Resident A is always thirsty. Resident A is known as a resident that will never refuse medications because it allows him to drink water. Staff Snay reported that she has no idea why a blood test would test negative for Lorazepam, and she is certain that she witnessed Resident A ingest the PRN on the 24th. Staff Snay also reported that staff members of the home are always aware of when meds have been passed.

On 7/6/23, I interviewed Don Eplett, direct care staff of the home. Staff Eplett has been working at Lakeside for 7 years and reported he knows Resident A very well. Staff Eplett reported that staff always get guardian's approval before passing the PRN. Staff Eplett stated he was the staff member that passed the Lorazepam on the 23rd of April. Staff Eplett reported that whether the PRN has an effect on Resident A's behavior varies from day to day. Staff Eplett reported he has no concerns about other staff members taking or not given Resident A his PRN and has heard no gossip or concern among other staff members regarding the taking of medications. Staff Eplett reported that, if he did hear concerns to this effect, he would immediately report it.

On 7/6/23, I interviewed Jessica Hansen, assistant manager for 1 year at the home. Hansen reported that she has been present for the passing of Resident A's PRN and that at times it works to change his behavior but at other times it doesn't. However, Jessica Hansen reported that every time she has initiated a PRN passing, she is certain Resident A has taken it. Jessica Hansen also confirmed that Resident A will always take his medication because it means he will get an opportunity to drink water. Jessica Hansen felt it was "very strange" that Lorazepam would not have shown up on a blood test but feels staff would not have withheld the medication in any way because they care about Resident A's safety and want him to be successful.

On 7/13/23 I visited the local hospital where Resident A was being held on the psych ward. While there I was able to interview Marcia Rogers, the director of adult psychiatry, about Resident A's intake to the facility and his behavior while there. Marica Rogers reported to me that Resident A was aggressive when he originally arrived in the emergency department. His behavior has required near-constant supervision and redirecting. From around July 4th Resident A's behavior has been stable with periodic banging on windows and doors while making demands and occasionally being threatening. Marica Rogers believed it is strange that Lorazepam would be negative in Resident A's blood but believes the sensitivity of the test may produce an unusual outcome. Marica Rogers told me that the half-life of Lorazepam is between 10-20 hours, and it would most certainly show up on a blood test that was conducted the day after being given dose.

On 7/13/23, I conducted an interview with Resident A who told me he likes living at Lakeside but also believes he is not ready to go back. I asked about his experience when staff giving him a PRN for his behaviors. Resident A is aware that his behaviors can escalate, and he can become difficult to control. But he told me that whenever he is given a PRN it is always present in the cup, they hand him, and he drinks it with water.

On 7/13/23, I spoke with Dr. George Krzymowski, director of laboratory services and chemistry at Upper Peninsula Health System. Dr. Krzymowski told me that he is certain a blood test given the day after being dosed with Lorazepam would definitely show positive for the drug. When told that Resident A has polydipsia, Dr. Krzymowski reported that there is no way anyone could drink enough water to dilute the presence of Lorazepam in one's blood to where it would not show up on a blood test. Further, there is no case that he is aware of in which one's liver would be able to metabolize Lorazepam at a rate at which it would not show up on a blood test.

On 8/23/23 I spoke again to Faye Witte who reported that she would not be finding any rights violations against the home. However, Witte told me that she was going to recommend changes with medication management at the home and we agreed that there may be too many people involved in passing medications and that, for the safety of staff and residents, it may be helpful to tighten up current medication passing practices at the home.

On 8/30/2023 I conducted an interview at Lakeside with home manager Koval. While there I received copies of the incident reports that I had reviewed at my original onsite inspection. Kaitlyn Koval informed me that Resident A is still inpatient at the hospital.

On 8/31/2023 I conducted an exit conference with administrator Tammy Unger and told her the results of the investigation. She had concerns about the fact that I had substantiated a rule violation, but Pathways recipient rights investigation had not. I informed her that I was not sure who everyone was that RRO Faye Witte had interviewed throughout the duration of her investigation but that, as a part of my investigation, the fact that Marcia Rogers and Dr. Krzymowski made it clear that they do not believe a blood test would show negative after 4 doses of Lorazepam in three days, factored heavily into my decision to cite a rule violation. Administrator Unger and I also discussed potential corrective actions including not having so many staff able to access medications and ensuring residents are swallowing their medications and not keeping them in their mouth for later disposal.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Faye Witte reported to me that on April 23rd Resident A was given two doses of Lorazepam, one at 10:15am and another at 2:50pm. On April 24th Resident A was given one dose at 9:30am. On April 25th Resident A was given one dose at 8:24am. All staff members confirmed this to me verbally and Resident A's MAR as well as the associated incident reports also detail the same information. However, on April 26th, Resident A went to the hospital to have his blood drawn and the results showed no trace of Lorazepam. Both Marcia Rogers and Dr. Krzymowski told me, independently, that they are certain a blood test given the day after being dosed with Lorazepam would definitely show positive for the drug. Based on the results of the blood test completed on Resident A on April 26, there is substantial evidence Resident A was not administered his PRN as documented.
CONCLUSION:	**VIOLATION ESTABLISHED**

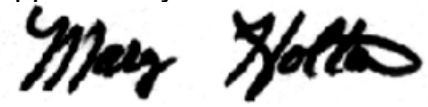
IV. RECOMMENDATION

Upon receipt of an appropriate corrective action plan, I recommend no changes to the status of this license.

8/31/23

Garrett Peters Date
Licensing Consultant

Approved By:



8/31/23

Mary E. Holton Date
Area Manager