



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 31, 2023

Sonia McKeown
JARC, Suite 100
6735 Telegraph Rd
Bloomfield Hills, MI 48301

RE: License #: AS630016142
Investigation #: 2023A0602026
Katzman

Dear Ms. McKeown:

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 (248) 975-5053.

Sincerely,

A handwritten signature in cursive script that reads "Cindy Berry". The signature is written in black ink on a white background.

Cindy Berry, Licensing Consultant
Bureau of Community and Health Systems
3026 West Grand Blvd
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 860-4475

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630016142
Investigation #:	2023A0602026
Complaint Receipt Date:	05/30/2023
Investigation Initiation Date:	05/30/2023
Report Due Date:	07/29/2023
Licensee Name:	JARC
Licensee Address:	Suite 100 6735 Telegraph Rd Bloomfield Hills, MI 48301
Licensee Telephone #:	(248) 403-6013
Administrator:	Sonia McKeown
Licensee Designee:	Sonia McKeown
Name of Facility:	Katzman
Facility Address:	5425 Pond Bluff Drive West Bloomfield, MI 48323
Facility Telephone #:	(248) 682-9374
Original Issuance Date:	03/13/1995
License Status:	REGULAR
Effective Date:	08/25/2022
Expiration Date:	08/24/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Per incident report, on 5/22/2023 Resident A did not receive his 8 am medication.	Yes

III. METHODOLOGY

05/30/2023	Special Investigation Intake 2023A0602026
05/30/2023	Special Investigation Initiated - Telephone Spoke with the licensee designee, Sonia McKeown.
06/15/2023	Inspection Completed On-site Interviewed the home manager, Lisa Green, staff member Taisha Brunson and reviewed Resident A's medication administration record (MAR).
08/30/2023	Exit Conference Held with the licensee designee, Sonia McKeown.

ALLEGATION:

Per incident report, on 5/22/2023 Resident A did not receive his 8 am medication.

INVESTIGATION:

On 5/30/2023, a complaint was received and assigned for investigation alleging that on 5/22/2023 Resident A did not receive his 8 am medication.

On 5/30/2023, I spoke with the licensee designee, Sonia McKeown by telephone. Ms. McKeown stated she was not aware of the incident but agreed to submit a corrective action if violations are established.

On 6/15/2023, I conducted an unannounced on-site investigation at which time I interviewed the home manager, Lisa Green, and staff member Taisha Brunson. Ms. Green stated that Ms. Brunson was the staff member who failed to administer Resident A his 8 am medication. According to Ms. Green, there are five residents who reside in the home and three of them are very chatty and constantly wants staff attention. She went on to state that she believes Ms. Brunson was distracted by the constant

questions and chatter from the three residents while administering the residents their medication. Resident A's physician was notified of the incident and instructed staff to omit the missed medication and proceed with the next dose as prescribed. Ms. Green said she was not informed of the incident until the next day. At that time, Ms. Brunson received written disciplinary action and was re-trained on medication administration.

On 6/15/2023, Ms. Brunson stated she began working in the home in March 2023 and at the time the incident occurred, she was fairly a new employee. She said she takes complete responsibility for the incident as it was a hectic morning, and she was distracted by the resident's busyness and constant chatting. Ms. Brunson stated she was written up and retrained on how to properly administer medication. Staff have also been working with the residents by re-directing them when they are asking staff questions when staff are administering medication. Ms. Brunson went on to state that she is now very cautious when administering medication and ensures that she is not distracted.

On 6/15/2023, I reviewed Resident A's MAR dated May 2023. As documented on the MAR, on 5/22/2023 Resident A did not receive the following 8 am medications, Finasteride, Levetiracetam, Olmesa Medox, and Tamsulosin. The medications were discarded.

On 8/30/2023, I conducted an exit conference with the licensee designee, Sonia McKeown. I informed Ms. McKeown of the investigative findings and recommendation documented in this report. Ms. McKeown agreed to submit a corrective action plan upon receipt of this report.

APPLICABLE RULE	
R 400.14312	Resident medications.
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on the information received from Ms. Green and Ms. Brunson, there is sufficient information to determine that Resident A did not receive his 8 am medications on 5/22/2023. According to Ms. Brunson, on 5/22/2023 she was distracted by the other residents and failed to administer Resident A his 8 am medications (Finasteride, Levetiracetam, Olmesa Medox, and Tamsulosin).
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

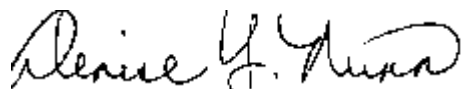


8/31/2023

Cindy Berry
Licensing Consultant

Date

Approved By:



08/31/2023

Denise Y. Nunn
Area Manager

Date