GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 13, 2023

Renee Ostrom
Residential Alternatives Inc
124B N Saginaw Street
Holly, MI 48442

RE: License #: AS630080974
Investigation #: 2023A0611032
Beacham CLF

Dear Ms. Ostrom:

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,

Sheena Worthy, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd, Suite 9-100
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630080974
Investigation #:	2023A0611032
Complaint Receipt Date:	09/26/2023
Investigation Initiation Date:	09/26/2023
Report Due Date:	11/25/2023
Licensee Name:	Residential Alternatives Inc
Licensee Address:	124B N Saginaw Street Holly, MI 48442
Licensee Telephone #:	(248) 369-8936
Administrator:	Renee Ostrom
Licensee Designee:	Renee Ostrom
Name of Facility:	Beacham CLF
Facility Address:	3278 Beacham Waterford, MI 48329
Facility Telephone #:	(248) 335-3280
Original Issuance Date:	08/04/1998
License Status:	REGULAR
Effective Date:	03/05/2023
Expiration Date:	03/04/2025
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Incidents reports were completed reporting that staff initials were not being documented on the MAR after the medications were administered to residents.	Yes

III. METHODOLOGY

09/26/2023	Special Investigation Intake 2023A0611032
09/26/2023	Special Investigation Initiated - Letter I emailed the recipient rights specialist Dawn O'Connor regarding additional information pertaining to the allegations.
09/26/2023	Contact - Document Received I received eight incident reports from recipient rights specialist, Dawn O'Connor regarding the allegations.
10/04/2023	Inspection Completed On-site I completed an unannounced onsite. I interviewed the home manager, Lashonda Lindsey, staff member, Elaine Lizardi, Resident D, and Resident J. I received copies of the MAR for the month of September for every resident.
10/10/2023	Contact – Document Received I received a copy of Resident S SMMO order stating his Repaglinide can be administered up to four hours late. I received a copy of Ms. Lindsey disciplinary action, medication and documentation training, and in-service training.
10/10/2023	Exit Conference I completed an exit conference with the licensee designee, Renee Ostrom via telephone. The allegations were discussed.

ALLEGATION:

Incidents reports were completed reporting that staff initials were not being documented on the MAR after the medications were administered to residents.

INVESTIGATION:

On 09/26/23, a complaint was received and assigned for investigation alleging that ORR received several incident reports indicating that staff member Laurel found several documentation errors and other concerns relating to the individuals living in the home between 9/20 and 9/23/23. This included medication packs/logs not completed/initialed, daily paperwork not completed etc. The provider noted that the manager received disciplinary action regarding the documentation that was missing and is being retrained on medication administration protocol.

On 09/26/23, I received an email from recipient rights specialist, Dawn O'Connor. Ms. O'Connor provided copies of eight incident reports pertaining to the allegations. Ms. O'Connor stated the following in her email:

> "The provider told me everything was handled, and she didn't have any concerns other than the documentation not being done. One topical med was missed, and it was given later. This is why I did not open it for a rights investigation."

On 09/26/23, I received eight incident reports from recipient rights specialist, Dawn O'Connor. The first incident report signed on 09/23/23 and completed by staff member, Laurel Bissinger indicates that 8:00pm medications were not administered when she arrived at 8:06pm. Resident J did not receive his Nystatin topical or his 4:00pm Lorazepam as it was not initialed on the MAR. The blister checks/med counts were not recorded for 09/21/23 or 9/22/23.

The second incident report signed on 09/23/23 and completed by staff member, Laurel Bissinger indicated that the home manager asked Ms. Bissinger to pass 8:00pm medications. Resident S did not receive his 5:00pm Repaglinide as there were no initials on the MAR nor were there any initials for Resident S 12:00pm dose for Repaglinide. Resident S's nail trim was undocumented.

The third incident report signed on 09/23/23 and completed by staff member, Laurel Bissinger indicated that Resident D did not wash his feet, nor did he receive his Clotrimazole. There was nothing documented about his bowel movements.

The fourth incident report signed on 09/23/23 and completed by staff member, Laurel Bissinger indicated that Resident G had feces on his shirt. Resident G is a rectal digger. The 8:00pm medications were not administered. There was nothing documented about Resident G's bowel movements.

The fifth incident report signed on 09/23/23 and completed by home manager, Lashonda Lindsey indicated that she did pass medications for Resident J but she did not sign for it.

The sixth incident report signed on 09/23/23 and completed by home manager, Lashonda Lindsey indicated that Resident G changed his shirt because he had pudding on it.

The seventh incident report signed on 09/23/23 and completed by home manager, Lashonda Lindsey indicated that she did pass medications for Resident S, but she did not sign for it.

The eighth incident report signed on 09/23/23 and completed by home manager, Lashonda Lindsey indicated that she did pass medications for Resident D, but she did not sign for it. She prompted Resident D to take a shower but, he refused to do so.

On 10/04/23, I completed an unannounced onsite. I interviewed the home manager, Lashonda Lindsey, staff member, Elaine Lizardi, Resident D, and Resident J. I received copies of the MAR for the month of September for every resident. I also received a copy of Ms. Lindsey training certificate for completing a medication refresher. Resident S and Resident G were at workshop during the onsite.

On 10/04/23, I interviewed the home manager, Lashonda Lindsey. Ms. Lindsey stated she has been the home manager for three years. There are four residents in the AFC group home. Ms. Lindsey stated Resident G is non-verbal. Resident S is verbal but, he is not capable of being interviewed. Regarding the allegations, Ms. Lindsey stated on 09/22/23 she worked the afternoon shift from 2:00pm to 8:00pm. Ms. Lindsey was the assigned medication passer during her shift. Ms. Lindsey stated all of the residents are prescribed a medication at 4:00pm except for Resident G. Ms. Lindsey stated she started passing the 4:00pm medications at 4:15pm. Ms. Lindsey stated Resident D was distracting her while she was administering Resident S medication as he was crying about not being able to go to a family members wedding. Ms. Lindsey stated instead of initialing the MAR after she administered Resident S medication, she started to administer Resident D's medication. Ms. Lindsey stated she did initial the residents bubble packets after she administered their medications, but she did not initial the MAR. Ms. Lindsey confirmed that she did not initial the MAR after she administered the 4:00pm medications for Resident S, Resident D, and Resident J.

Ms. Lindsey explained that whenever the next shift starts, the assigned medication passer for the next shift is supposed to check the medications and the MAR to ensure the medications have been administered by the previously assigned medication passer. Ms. Lindsey stated staff member, Laurel Bissinger arrived on her shift at 8:00pm. At this time, Ms. Lindsey left the AFC group home as her shift ended. Ms. Bissinger was the assigned medication passer during her shift. When Ms. Bissinger started administering medications, she contacted Ms. Lindsey. Ms. Bissinger informed Ms. Lindsey that she

did not document Resident S's MAR when she administered his Miralax at 4:00pm. Ms. Lindsey told Ms. Bissinger that she may forgot to document the MAR but, she did administer the medication. Ms. Lindsey stated she informed Ms. Bissinger that she will come to the AFC group home tomorrow to check the MAR. Ms. Lindsey stated Ms. Bissinger called the police about the MAR not being documented. Ms. Bissinger was advised by the police to contact her supervisor. Ms. Bissinger contacted the licensee designee, Renee Ostrom. Ms. Bissinger informed Ms. Ostrom that Ms. Lindsey did not initial the MAR when she administered the 4:00 medications, she didn't prep Resident D's feet for his foot cream, and she didn't administer 8:00pm medications. Ms. Ostrom informed Ms. Bissinger that she was responsible to administer 8:00pm medications. Ms. Ostrom arrived to the AFC group home between 3:00am-4:00am on 09/23/23. Ms. Lindsey stated she arrived to the AFC group home at 12:00pm. Ms. Lindsey stated Ms. Ostrom circled all the missing staff initials on the MAR which included the 4:00pm medications and the 8:00pm medications on 09/22/23. When Ms. Ostrom arrived to the AFC group home, Ms. Bissinger told Ms. Ostrom that she quits, and she left the home before her shift was over. Ms. Ostrom contacted another staff member to cover Ms. Bissinger shift.

Ms. Lindsey stated staff member, Elaine Lizardi was present at the AFC group home on 09/22/23 and; her shift ended at 8:30pm. Ms. Lindsey completed a medication re-fresher training on 09/28/23. Ms. Lindsey did receive disciplinary action for not initialing the MAR when she administered medications. Ms. Lindsey denied ever telling Ms. Bissinger to falsify documentation including the MAR. Ms. Lindsey also denied Resident G having feces on his shirt. Ms. Lindsey explained that Resident G had chocolate pudding on his shirt and, she assisted him with changing his shirt. Ms. Lindsey stated she starts prompting Resident D to wash his feet at 7:00pm because he will refuse to do it and; if he does agree to wash his feet it will happen between 9:30pm-10:00pm. Resident D's cream has to be applied to his feet after he washes them.

On 10/04/23, I interviewed staff member, Elaine Lizardi. Ms. Lizardi was re-hired on 09/10/23. Prior to Ms. Lizardi being re-hired, she worked for the AFC group home for three years. Regarding the allegations, Ms. Lizardi stated she saw Ms. Lindsey administered 5:00pm medications for Resident S. Ms. Lizardi also saw Ms. Lindsey administer 4:00pm medications to Resident D, Resident S, and Resident J. Ms. Lizardi stated she was cleaning the kitchen and preparing dinner when Ms. Lindsey was administering medications. The medication room is located in the laundry room next to the kitchen. Ms. Lizardi does not know if Ms. Lindsey initialed the MAR after she administered medications. When Ms. Lindsey shift ended, Ms. Bissinger started her shift. Ms. Bissinger administered 8:00pm medications. Ms. Lizardi stated she only saw Ms. Bissinger administer Resident S medications. Ms. Lizardi stated she was trained this week to administer medications. The 5 rights were discussed with Ms. Lizardi.

On 10/04/23, I interviewed Resident D. Regarding the allegations, Resident D stated he likes living at the AFC group home but, he is ready to move in with family. Resident D did not report any concerns regarding the home or the staff. Resident D stated he takes medication everyday provided by the staff. Resident D stated the staff never forget to

give him his medications. Resident D stated he takes a shower every other day. Resident D stated he washes his feet every day and; he does not require assistance from staff.

On 10/04/23, I interviewed Resident J. It was hard to understand Resident J during his interview. Regarding the allegations, Resident J stated he likes living at the AFC group home. Resident J stated he takes medications every day provided by the staff. Resident J stated the staff never forget to give him his medications. Resident J stated the staff takes care of him. Resident J did not report any concerns regarding the AFC group home.

On 10/04/23, I received copies of the MAR for the month of September for all the residents. The staff initial the MAR by documenting a number they are assigned to. Ms. Lindsey stated her number is 13 and Ms. Bissinger number is 6. Regarding the MAR for Resident G, there was no staff initial for his Belsomra 10 mg at 8:00pm on 09/22/23. Regarding the MAR for Resident S, Ms. Bissinger initials were observed for Resident S 5:00pm dose for his Repaglinide on 09/22/23. However, according to the incident reports, Ms. Bissinger did not arrive on shift until 8:06pm on 09/22/23.

According to the MAR for Resident D, there were no staff initials for his Clotrimazole at 8:00pm on 09/22/23. There were no staff initials for his Polyethylene at 4:00pm on 09/22/23. Regarding the MAR for Resident J, there were no staff initials for his Lorazepam at 4:00pm on 09/22/23.

On 10/10/23, I completed an exit conference with the licensee designee, Renee Ostrom via telephone. Regarding the allegations, Ms. Ostrom stated she received a phone call from Ms. Bissinger around 4:00am (9/22/23) informing her that she had called the police and she needed her to relieve her. Ms. Bissinger also stated that Ms. Lindsey asked her to falsify information by documenting on the MAR to indicate Ms. Lindsey passed a medication. Ms. Ostrom stated when she arrived to the AFC group home at 4:45 am, Ms. Bissinger quit and left the AFC group home.

Ms. Ostrom stated Ms. Lindsey did not document that she passed Resident J 4:00pm Lorazepam, Resident S 5:00pm Repaglinide, Resident D foot cream, or Resident S and Resident D Miralax. Ms. Ostrom explained that although Ms. Bissinger did not arrive to her shift on 09/22/23 until on or about 8:00pm, she administered Resident S 5:00pm dose of Repaglinide as per his SMMO (standard missed medication order) this medication can be given up to four hours late. Ms. Ostrom stated she will provide a copy of the SMMO order. Ms. Ostrom confirmed that Ms. Bissinger was the assigned medication passer for 8:00pm medications on 09/22/23. Ms. Ostrom will provide a copy of Ms. Lindsey disciplinary action.

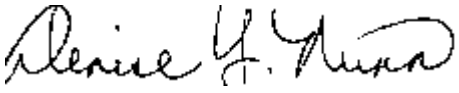
APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	The home manager, Lashonda Lindsey confirmed that on 09/22/23, she did not initial the MAR after she administered the residents medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

10/11/23
Sheena Worthy — Date
Licensing Consultant

Approved By:



10/13/2023
_____
Denise Y. Nunn — Date
Area Manager