GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 7, 2023

Melanie Love
Alternative Community Living, Inc.
P. O. Box 190179
Burton, MI 48519

RE: License #: AS250274209
Investigation #: 2024A0572005
Westwood

Dear Ms. Love:

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,

Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250274209
Investigation #:	2024A0572005
Complaint Receipt Date:	10/26/2023
Investigation Initiation Date:	10/31/2023
Report Due Date:	12/25/2023
Licensee Name:	Alternative Community Living, Inc.
Licensee Address:	P. O. Box 190179 Burton, MI 48519
Licensee Telephone #:	(810) 265-6040
Administrator:	Paul Smyth
Licensee Designee:	Melanie Love
Name of Facility:	Westwood
Facility Address:	2820 Westwood Flint, MI 48503
Facility Telephone #:	(810) 424-9030
Original Issuance Date:	05/09/2005
License **Status:**	REGULAR
Effective Date:	11/06/2023
Expiration Date:	11/05/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff gave Resident A the wrong insulin on 10/20/2023. Staff gave Resident A 30 units of Novolog insulin instead of 30 units of Levemir.	Yes

III. METHODOLOGY

10/26/2023	Special Investigation Intake 2024A0572005
10/31/2023	Special Investigation Initiated - On Site Home Manager, Paul Smyth and Resident A.
10/31/2023	Contact - Face to Face Staff, Unalysia Jones.
11/01/2023	Contact - Document Sent Email, Matt Potts.
11/02/2023	Inspection Completed-BCAL Sub. Compliance
11/03/2023	Exit Conference Licensee Designee, Melanie Love.
11/07/2023	APS Referral APS referral was made.

ALLEGATION:
Staff gave Resident A the wrong insulin on 10/20/2023. Staff gave Resident A 30 units of Novolog insulin instead of 30 units of Levemir.

INVESTIGATION:
On 10/26/2023, the local licensing office received a complaint for investigation. Recipient Rights are also conducting their own investigation.

On 10/31/2023, an unannounced onsite was conducted at Westwood, located in Genesee County. Interviewed were Home Manager, Paul Smyth and Resident A.

On 10/31/2023, I interviewed Home Manager, Paul Smyth regarding the allegation. Mr. Smyth informed that the allegation is true, that Staff, Unalysia Jones had given Resident A the incorrect insulin. They contacted the Primary Care Physician and was informed to take Resident A to emergency room for precaution because they were dealing with insulin. Resident A was deemed fine and in good health following their evaluation. An incident report was written. Mr. Smyth informed that Staff, Unalysia Jones does not work until 3pm. I will come back later to interview Ms. Jones.

On 10/31/2023, I interviewed Resident A regarding the allegation. She remembers when she was given the incorrect insulin. She said that she was not in any pain or discomfort. Resident A had just finished eating in the dining room and appeared to be receiving appropriate care and supervision.

On 10/31/2023, I reviewed the medication sheet and instructions for the insulin. According to Resident A's med sheet, if the blood sugar is less than 120, then Resident A is to be injected with the Levemir 100. If blood sugar is above 150, then Novolog is to be injected. According to the med sheet, Resident A was at 155, so she should have received Novolog 100 instead.

On 10/31/2023, I reviewed the Incident Report (IR) and it indicates that Staff, Ms. Unalysia Jones administered the wrong insulin to Resident A. The Home Manager advised staff to contact the Primary Care Physician who advised staff to call 911. As a corrective measure, Ms. Jones will double check the medication prior to administering to the residents.

On 10/31/2023, I went back to the home to speak with Staff, Unalysia Jones regarding the allegation. Ms. Jones informed that it was true. She had gotten very busy and accidentally drew up the wrong insulin medication for Resident A. Ms. Jones denied that anything in the med cart was out of order and that she just made a mistake. After administering another resident their insulin, it dawned on her that she had made the mistake. Staff Jones had called the Nurse Practitioner and she told her to call an ambulance to take Resident A to the emergency room. Ms. Jones followed the ambulance to the hospital and sat with Resident A for 6 hours. Resident A was monitored for 6 hours because the Levemir 100 drops the blood sugar very

quickly, so they wanted to make sure that her blood sugar levels stayed at a normal level.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on my investigation, there is enough evidence to establish a violation of licensing rules. Both the Home Manager, and staff, Ms. Jones informed that Ms. Jones inadvertently given out the incorrect insulin to Resident A. The med sheet and incident report also confirms the error.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/03/2023, an Exit Conference was held with Licensee, Melanie Love regarding the allegation. Ms. Love was informed that a citation would be issued for the medication error.

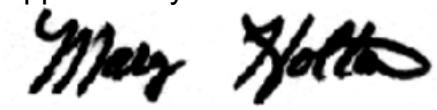
IV. RECOMMENDATION

I recommend no changes to the licensing status of this small adult foster care group home pending the receipt of an approved corrective action plan (Capacity 1-6).

11/07/2023

Anthony Humphrey — Date
Licensing Consultant

Approved By:



11/07/2023

Mary E. Holton — Date
Area Manager