GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 12, 2023

Kimberly Kemp
Woods Care
PO Box 1107
Wayne, MI 48184-4107

RE: License #: AS820313478
Investigation #: 2023A0116014
Beyond Boundaries

Dear Ms. Kemp:

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 (313) 456-0380.

Sincerely,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820313478
Investigation #:	2023A0116014
Complaint Receipt Date:	12/13/2022
Investigation Initiation Date:	12/15/2022
Report Due Date:	02/11/2023
Licensee Name:	Woods Care
Licensee Address:	5706 Wayne Road Wayne, MI 48184
Licensee Telephone #:	(734) 355-2624
Administrator:	Kimberly Kemp
Licensee Designee:	Kimberly Kemp
Name of Facility:	Beyond Boundaries
Facility Address:	11274 Moore Street Romulus, MI 48174
Facility Telephone #:	(734) 355-2624
Original Issuance Date:	10/11/2011
License Status:	REGULAR
Effective Date:	04/17/2022
Expiration Date:	04/16/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A moved into the facility on November 05, 2022. It was discovered that six of his medications were not administered for the month of November. However, some days the medication log was initialed indicating the medication was given.	Yes

III. METHODOLOGY

12/13/2022	Special Investigation Intake 2023A0116014
12/13/2022	Referral-Recipient Rights Made.
12/13/2022	APS referral Made by Recipient Rights.
12/15/2022	Special Investigation Initiated - On Site Interviewed staff, Renee Davis, and Resident A. Reviewed Resident A's medication administration records (MARs) and medications.
12/20/2022	Contact - Document Received Received a copy of the doctor order that discontinued the use of his Exelon patch.
12/15/2022	Inspection Completed-BCAL Sub. Compliance
01/05/2023	Exit Conference With licensee designee, Kimberly Kemp.

ALLEGATION:

Resident A moved into the facility on November 05, 2022. It was discovered that five of his medications were not administered for the month of November. However, some days the medication log was initialed indicating the medication was given.

INVESTIGATION:

On 12/15/22, I conducted an unscheduled onsite inspection and interviewed staff, Renee Davis, Resident A, reviewed Resident A's November and December 2022 medication administration records (MARs), and his current medications. Ms. Davis confirmed that Resident A moved into the home on 11/05/22, after being discharged from the hospital. Ms. Davis reported that Resident A's previous home closed. Ms. Davis reported that licensee designee, Kimberly Kemp, assisted Resident A with the move into the home and was the person who received the MARs and medication from the previous home. Ms. Davis reported they were using the MARs from the previous home, while waiting to switch Resident A over to the pharmacy that they use. Ms. Davis reported that after Ms. Kemp reviewed all of Resident A's medications and MARs and spoke to his doctors, she determined that several of the medications that were listed, Resident A had stopped taking months ago. Ms. Davis reported that the previous home never had the medications removed from the MARs.

Ms. Davis reported that Resident A's supports coordinator conducted a home visit a couple weeks ago and took issue with the medications and MARs after finding errors, that have sense been rectified. Ms. Davis reported that all she knows is that some staff were initialing the MARs for medication that was not in the home, and other staff were administering medication and failing to initial the MARs as required. Ms. Davis reported that Ms. Kemp has obtained all new/updated prescriptions from Resident A's doctors and his MARs have all been updated. Ms. Davis also reported that she is working on getting verification from Resident A's doctor that the 9.5 mg Exelon patch, was discontinued prior to Resident A's admission into the home. Ms. Davis reported she would send me a copy once she obtains it. Ms. Davis further reported any additional information needed could be obtained from Ms. Kemp.

I interviewed Resident A and he reported that he is doing good, the staff treat him nice, and he gets his medications daily. Resident A reported to his knowledge staff give him all of his prescribed medications. Resident A further reported so far, he has nothing negative to report.

I reviewed Resident A's November and December MARs as well as his medications. I observed that during the month of November '22 the following medications were not initialed as given:

- Omeprazole 20mg capsule and Amlodipine Besylate 5mg tablet was not initialed as given on 11/09/22, 11/10/22, 11/16/22-11/20/22,11/22/22, and 11/25/22-11/29/22.
- Triamcinolone 0.1% ointment was not initialed the entire month of November.
- Ventolin HFA 90mcg inhaler was not initialed as given from 11/05/22-11/21/22 or 11/24/22-11/30/22.
- Phenytoin 50mcg chews (am dose) were not initialed as given from 11/16/22-11/29/22.

- Phenytoin 50mcg chews (pm dose) was not initialed as given for the entire month of November.
- Lisinopril 20mg tablet not initialed as given on 11/09/22 and 11/29/22.
- Ketoconazole 2% cream was not initialed as given the entire month of November.
- PEG 3350 17 gm packet was not initialed as given for the entire month of November.

I reviewed Resident A's December '22 MARs and observed that staff had initialed all medications as given. I also observed that several medications that I observed on the previous MARs had been discontinued and were no longer reflected on the December MARs. I also reviewed Resident A's medications, matched them to the MARs and confirmed that they are being administered as prescribed.

On 12/20/22, I received a copy of the discontinue order for Resident A's Exelon Patch. The order documents that the patch was discontinued in 2021.

On 01/05/23, I interviewed and conducted the exit conference with licensee designee, Kimberly Kemp. Ms. Kemp reported that she takes responsibility for her part in this matter. Ms. Kemp reported that the home Resident A was previously residing in was closing on 10/28/22. She reported that Resident A was in the hospital at the time. Ms. Kemp reported she went to the other home and got all Resident A's belongings and met with the home manager. Ms. Kemp reported that she made a mistake by not going over all of Resident A's current medications and his MARs to make sure everything was accurate. Ms. Kemp reported had she done so, some of the issues with the medication and MARs would not have occurred. Ms. Kemp reported that she met with both of Resident A's doctors who prescribe his medications and obtained all new prescriptions for his current medications. Ms. Kemp reported that it was during that meeting that she was informed that many of the medications and topicals had previously been discontinued, but the previous home failed to have them removed from Resident A's MARs.

Ms. Kemp further reported that she conducted an internal investigation and found that two staff, Leanna Hale, and Tatayana Johnson were initialing for medications that were not in the home, failing to initial some medications at the time of administration, and when a medication ran out, failed to inform her so that the medication could be refilled, but continued to initial the MARs indicating that the medication was administered. Ms. Kemp reported that Ms. Hale was suspended for three days without pay and retrained in the proper administration of medication. Ms. Kemp reported that Ms. Johnson received a written reprimand and was also retrained in the proper administration of medication. Ms. Kemp reported that all of the medication issues have been rectified.

I informed Ms. Kemp of my observations during the onsite and shared with her that although the medication issues are rectified, at the time of my onsite inspection they were not. I informed Ms. Kemp of the rules that would be cited and the need for a corrective action plan. Ms. Kemp reported an understanding and reported this would not happen again.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.

ANALYSIS:	Based on the findings of the investigation, which included interviews of Ms. Davis, Resident A, Ms. Kemp and consultant observation, I am able to corroborate the allegations. Ms. Davis reported that some of the staff were initialing the MARs for medication that was not in the home and that had not been administered to Resident A, although it was prescribed. Resident A reported to his knowledge staff has been giving him all of his prescribed medications. Ms. Kemp confirmed that she discovered during her internal investigation that staff Leanna Hale and Tatayana Johnson, were initialing the MARs for medication that they were not administering. Ms. Kemp reported that Resident A had run out of medications and staff did not inform her so that the medication could be refilled. Ms. Kemp reported that Ms. Hale and Ms. Johnson just continued to initial the MAR as if they had administered the medication. I observed Resident A's November '22 MARs and observed several medications that were not initialed as given for days, and others that were not administered or applied for the entire month of November. This violation is established, as Resident A's prescription medication was not given or applied as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.**

	(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given. **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	Based on the findings of the investigation, which included interviews of Ms. Davis, Ms. Kemp and consultant observation, I am able to corroborate the allegations. Ms. Davis reported that some of the staff were administering medications and failing to initial the MAR. Ms. Kemp reported that she also confirmed during her internal investigation that staff, Leanna Hale and Tatayana Johnson were administering medications to Resident A, but failed to initial the MAR at the time of administration. I observed Resident A's November '22 MARs during my onsite inspection on 12/15/22. I discovered during the month of November '22 several medications documented on the MARs did not contain the initials of the person who administered the medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

Pandrea Robinson
Licensing Consultant

01/09/23
Date

Approved By:

01/12/23

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Ardra Hunter Date
Area Manager