GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 11, 2024

Rebecca Lopez
Residential Opportunities, Inc.
1100 South Rose Street
Kalamazoo, MI 49001

RE: License #: AM390382558
Investigation #: 2024A0581021
Wisner House

Dear Rebecca Lopez:

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) 284-9730.

Sincerely,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM390382558
Investigation #:	2024A0581021
Complaint Receipt Date:	02/23/2024
Investigation Initiation Date:	02/26/2024
Report Due Date:	04/23/2024
Licensee Name:	Residential Opportunities, Inc.
Licensee Address:	1100 South Rose Street Kalamazoo, MI 49001
Licensee Telephone #:	(269) 343-3731
Administrator:	Diane Fidler
Licensee Designee:	Rebecca Lopez
Name of Facility:	Wisner House
Facility Address:	2208 East Cork Street Kalamazoo, MI 49001
Facility Telephone #:	(269) 381-1455
Original Issuance Date:	10/15/2018
License Status:	REGULAR
Effective Date:	04/14/2023
Expiration Date:	04/13/2025
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION

	Violation Established?
On 12/20/2023, direct care staff administered Resident B's 8 pm medication to Resident A.	Yes

III. METHODOLOGY

02/23/2024	Special Investigation Intake 2024A0581021
02/23/2024	Referral - Recipient Rights ISK is already investigating, no referral necessary.
02/26/2024	Contact - Document Received Email with ISK RRO, Briana Jackson.
02/26/2024	Special Investigation Initiated - Telephone Interview with direct care staff, Tah-Zay Gardner.
02/26/2024	Contact - Document Sent Email Program Director and Administrator requesting updated IR and copy of disciplinary action for staff.
02/26/2024	Exit conference with Administrator and Program Manager, via email.
02/27/2024	Contact - Document Received Email from Tara Cyrocki, program director.
02/27/2024	Inspection Completed On-site Interviewed Administrator, Diane Fidler, and staff, Mr. Gardner.
02/28/2024	APS Referral- Made APS referral via email.
03/06/2024	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: On 12/20/2023, direct care staff administered Resident B's 8 pm medication to Resident A.

INVESTIGATION: On 02/23/2024, I received the complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged on 12/20/2023 direct care staff, Tah-zay Gardner, gave Resident B's 8 pm medications to Resident A.

On 02/26/2024, I confirmed Integrated Services of Kalamazoo (ISK) Office of Recipient Rights (ORR) also received the allegations and investigated. Recipient Rights Officer, Briana Jackson, emailed me a copy of the Incident Report (IR) completed by Mr. Gardner documenting the medication error.

The IR, dated 12/20/2023 and completed by staff, Tah-Zay Gardner, documented he was passing 8 pm medications to Resident A, but "accidently gave the wrong meds to" Resident A. The IR documented "staff followed protocol, let supervisor know and called [Resident A's] doctor. Staff did not pass [Resident A's] 8 pm meds per doctor's orders. Doctor said [Resident A] can resume meds regular tomorrow". No additional information was documented in the IR.

On 02/26/2024, I interviewed direct care staff, Tah-Zay Gardner, via telephone. Mr. Gardner's statement to me was consistent with what was documented in the IR. He stated he had Resident A's medications and Resident B's medications right next to one another because they were in alphabetical order. Mr. Gardner stated he was trained on administering medications and knows how to administer them, but on that night, he felt rushed and overwhelmed and subsequently made an error. He stated upon realizing the error, he immediately contacted Resident A's physician who instructed Mr. Gardner to not administer Resident A's actual 8 pm medications. Mr. Gardner stated Resident A's physician also instructed he monitor Resident A for any changes in behavior. Mr. Gardner stated Resident A appeared fine throughout the night and received his morning medications, as prescribed. Mr. Gardner stated after contacting Resident A's physician, he contacted the facility's Administrator, Diane Filder.

Mr. Gardner stated the medications erroneously administered to Resident A were there following:

- Aripiprazole 5 mg tablet
- Ativan .5 mg tablet
- Sertraline HCL 200 mg tablets
- Simvastatin 40 mg tablet

Mr. Gardner stated Resident B received all his 8 pm medications on 12/20/2023, as prescribed.

On 02/26/2024, the facility's Program Director, Tara Cyrocki, sent via email a copy of Mr. Gardner's "PERFORMANCE DEFICIENCY REPORT" dated 02/21/2024. According to this report, Mr. Gardner received a "Reprimand" because he "passed an individual medication meant for another individual". The report documented the expected behavior for Mr. Gardner was to "…follow ROI's standard regarding Medication Passing – Best Practice". Also attached to the deficiency report was a copy of a facility staff meeting, dated 02/16/2024, which covered the licensee's policy on "Standards Regarding Medication Passing – Best Practice". Though Mr. Gardner did not attend the meeting, he signed the document by his next shift after the meeting, dated 02/21/2024, attesting he reviewed the information provided during the meeting and asked a supervisor for verbal clarification and details.

On 02/27/2024, I conducted an unannounced inspection. I interviewed the facility's Administrator, Diane Fidler. Ms. Fidler stated after talking to Mr. Gardner about the incident, it appeared another resident was experiencing a lot of behaviors, which caused the staff to be stressed and distracted. Ms. Fidler stated Resident A was supposed to receive the following medications at 8 pm on 12/20/2024:

- Paroxetine 30 mg tablet
- Quetiapine Fumarate 600 mg tablets
- Lactase 3000U caplets
- PEG 3350 PWD UD (Clearlax)
- Risperidone 2 mg tablet

Mr. Gardner was present during the inspection and demonstrated how medications were prepared and how the medication error occurred.

I reviewed both Resident A's and Resident B's December *Medication Administration Records* (MARs), which confirmed Resident B's medications administered to Resident A and the medications Resident A did not receive.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	Based on direct care staff, Tah-Zay Gardner's own admission, on 12/20/2024 on or around 8 pm he administered Resident B's medications, which consisted of Aripiprazole 5 mg tablet, Ativan .5 mg tablet, Sertraline HCL 200 mg tablets, Simvastatin 40 mg tablet to Resident A. Subsequently, not only did Resident A receive Resident B's medications, but he did not receive his prescribed medications, which consisted of Paroxetine 30 mg tablet, Quetiapine Fumarate 600 mg tablets, Lactase 3000U caplets, PEG 3350 PWD UD (Clearlax), and Risperidone 2 mg tablet, as prescribed. Consequently, on 12/20/2023, direct care staff, Tah-zay Gardner, did not administer Resident A's 8 pm medications, as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 02/26/2024, I conducted the exit conference with the Program Director, Tara Cyrocki and the Administrator, Diane Fidler, via email informing them of my findings.

IV. RECOMMENDATION

Based upon an acceptable plan of correction, I recommend no change in the current license status.

03/06/2024

Cathy Cushman Date
Licensing Consultant

Approved By:

03/11/2024

Dawn N. Timm Date
Area Manager