



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 18, 2024

Deana Fisher
St. Louis Center for Exceptional Children & Adults
16195 Old US-12
Chelsea, MI 48118

RE: License #: AS810409202
Investigation #: 2024A0122015
Kay & Russ House

Dear Ms. Fisher:

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) 284-9720.

Sincerely,

A handwritten signature in black ink that reads "Vanita Bouldin". The signature is written in a cursive, slightly slanted style.

Vanita C. Bouldin, Licensing Consultant
Bureau of Community and Health Systems
22 Center Street
Ypsilanti, MI 48198
(734) 395-4037

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS810409202
Investigation #:	2024A0122015
Complaint Receipt Date:	03/15/2024
Investigation Initiation Date:	03/15/2024
Report Due Date:	05/14/2024
Licensee Name:	St. Louis Center for Exceptional Children & Adults
Licensee Address:	16195 Old US-12 Chelsea, MI 48118
Licensee Telephone #:	(734) 475-8430
Administrator:	Deana Fisher
Licensee Designee:	Deana Fisher
Name of Facility:	Kay & Russ House
Facility Address:	1655 Hayes Rd. Chelsea, MI 48118
Facility Telephone #:	(734) 475-8430
Original Issuance Date:	08/11/2021
License Status:	REGULAR
Effective Date:	02/11/2024
Expiration Date:	02/10/2026
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A received the wrong medication for two weeks.	Yes

III. METHODOLOGY

03/15/2024	Special Investigation Intake 2024A0122015 APS Referral
03/15/2024	Special Investigation Initiated - Telephone Completed interview with Complainant 1 on 03/14/2024.
03/15/2024	Contact - Document Received Received file information from Deana Fisher, Licensee Designee via email.
03/15/2024	Exit Conference Discussed findings with Deana Fisher, Licensee Designee.

ALLEGATION: Resident A received the wrong medication for two weeks.

INVESTIGATION: On 03/14/2024, I completed an interview with Complainant 1. Complainant 1 stated she had been informed that Resident A received the medication Haldol 2 times per day, however, he was not prescribed this medication by his physician. Complainant 1 stated the pharmacy, One Care Pharmacy, sent Haldol to Resident A when they should have sent the medication Risperidone. Per Complainant 1, staff members did not detect the medication error for two weeks.

On 03/15/2024, Deana Fisher, Licensee Designee, submitted the following statement via email: "It appears that the pharmacy mislabeled a bottle of Haldol as Risperidone. The staff checked the label on the box but didn't realize that the words on the box did not match the pharmacy label. Nursing caught it when she went to refill the prescription. It appears he was given Haldol instead of Risperidone for 2 weeks."

Ms. Fisher further reported, "as soon as we found the error, we contacted the pharmacy, Nick's psychiatrist, his primary care, and his family. He has now returned to the correct prescription. There was no adverse reaction to the medication, and neither his psychiatrist nor his doctor recommended any treatment. We have also

notified his Community Mental Health worker and Recipient Rights in his county. (Marquette)”

On 03/15/2024, I reviewed documents submitted from Resident A’s file: The incident report dated 03/12/2024 documents that staff members detected and reported the medication error and a picture showing the pharmacy container of Haldol medication with the pharmacy label listing Risperidone as the medication with directions.

On 03/15/2024, I completed an exit conference with Deana Fisher, Licensee Designee. My findings were discussed with Ms. Fisher to which she agreed with. Ms. Fisher stated she would submit a corrective action plan to address rule violation found.

APPLICABLE RULE	
R 400.14312	Resident medications.
	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 S333.1101 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:	Resident A received the medication, Haldol, in error for two weeks. Complainant 1 and Deana Fisher, Licensee Designee, confirmed that Resident A received the medication Haldol in error for two weeks. Based upon my investigation I find that Resident A did not receive medication as prescribed. He received the medication, Haldol, in error for two weeks and the medication was not prescribed by his physician.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt and approval of a corrective action plan, I recommend no change in the status of the license.



Vanita C. Bouldin
Licensing Consultant

Date: 03/15/2024

Approved By:



Ardra Hunter
Area Manager

Date: 03/18/2024