GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 7, 2024

Donna Cross
193 S. Elm
Hesperia, MI 49421

RE: License #: AS640295294
Investigation #: 2024A0870023
A New Beginning

Dear Donna Cross:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On May 2, 2024, you submitted an acceptable written corrective action plan. It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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 (231) 922-5309.

Sincerely,

Bruce A. Messer, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 342-4939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS640295294
Investigation #:	2024A0870023
Complaint Receipt Date:	04/30/2024
Investigation Initiation Date:	05/02/2024
Report Due Date:	06/29/2024
Licensee Name:	Donna Cross
Licensee Address:	193 S. Elm Hesperia, MI 49421
Licensee Telephone #:	(810) 334-9880
Name of Facility:	A New Beginning
Facility Address:	298 Hawley Hesperia, MI 49421
Facility Telephone #:	(231) 854-0131
Original Issuance Date:	06/16/2008
License Status:	REGULAR
Effective Date:	12/16/2022
Expiration Date:	12/15/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Prescribed medications were located in Resident A's bedroom.	Yes
Resident A stated that she had to administer her own eye drops.	Yes

III. METHODOLOGY

04/30/2024	Special Investigation Intake 2024A0870023
05/02/2024	Special Investigation Initiated - On Site Interview with Licensee Donna Cross.
05/02/2024	Inspection Completed-BCAL Sub. Compliance
05/02/2024	Exit Conference Completed with Licensee Donna Cross.
05/02/2024	Corrective Action Plan Requested and Due on 05/02/2024.
05/02/2024	Corrective Action Plan Received.
05/02/2024	Corrective Action Plan Approved.

ALLEGATION: Prescribed medications were located in Resident A's bedroom.

INVESTIGATION: On May 2, 2024, I conducted an unannounced on-site special investigation at the A New Beginning AFC home. I met with Licensee Donna Cross and informed her of the above stated allegations. Ms. Cross explained about a week ago Resident A was taken to her eye doctor and was prescribed the medication Olopatadine 0.1% solution. She noted that Resident A was transported to and from her appointment by a medical transporter from PACE (Program for All-inclusive Care for the Elderly). Ms. Cross noted that the PACE transporter did not provide her with any information from Resident A's appointment when Resident A returned to the facility. Later that same day, a delivery person from the local pharmacy delivered a package, which contained the eye drops prescribed for Resident A, to the facility and Ms. Cross noted she handed the package to Resident A. Ms. Cross stated she gave the package containing the eye drops to Resident A "by mistake" and Resident A kept the eye drops in her bedroom, dispensing the drops to herself. Ms. Cross stated that once she was aware the delivery from the pharmacy contained a prescription medication, the Olopatadine eye drops, she then

secured the eye drops in the facility medication cabinet and is now dispensing the drops to Resident A herself.

During my interview with Ms. Cross, she unlocked the facility medication cabinet. I observed that prescription eye drops, Olopatadine, prescribed to Resident A, are now being secured in a locked cabinet.

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 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's prescription eye drop medication, Olopatadine, were given to Resident A who kept them in her bedroom. The Licensee failed to keep Resident A's prescription medication in a locked cabinet or drawer.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A stated that she had to administer her own eye drops.

INVESTIGATION: Ms. Cross stated she was unaware Resident A had been prescribed eye drops, Olopatadine, and that Resident A was dispensing the eye drops to herself. Ms. Cross noted that once she became aware that Resident A had the prescribed eye drops, she secured them in a locked cabinet and has been dispensing the eye drops to Resident A herself.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(3) Unless a resident's physician specifically states otherwise in writing, the giving, taking, or applying of prescription medications shall be supervised by the licensee, administrator, or direct care staff.

ANALYSIS:	The Licensee failed to supervise the application of Resident A's prescription eye drops.
CONCLUSION:	VIOLATION ESTABLISHED

On May 2, 2024, I provided Licensee Donna Cross with an exit conference. I explained my findings as noted above. Ms. Cross stated she understood and had no further information to provide, or questions to ask, concerning this special investigation. Ms. Cross had already made appropriate corrections and had secured Resident A's prescription eye drops in the facility medication cabinet. She is now dispensing the eye drops to Resident A. Ms. Cross provided me with a written corrective action plan to address the two cited AFC rule violations.

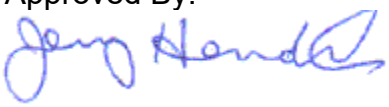
IV. RECOMMENDATION

An acceptable Corrective Action Plan has been received. I recommend the status of the license remain unchanged.

May 7, 2024

Bruce A. Messer — Date
Licensing Consultant

Approved By:



May 7, 2024

Jerry Hendrick — Date
Area Manager