GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 16, 2024

James Pilot
Bay Human Services, Inc.
P O Box 741
Standish, MI 48658

RE: License #:	AS090395688
Investigation #:	2024A0872031
	Rose Home

Dear James Pilot:

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,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS090395688
Investigation #:	2024A0872031
Complaint Receipt Date:	04/04/2024
Investigation Initiation Date:	04/05/2024
Report Due Date:	06/03/2024
Licensee Name:	Bay Human Services, Inc.
Licensee Address:	PO Box 741 3463 Deep River Rd Standish, MI 48658
Licensee Telephone #:	(989) 846-9631
Administrator:	Tammy Unger
Licensee Designee:	James Pilot
Name of Facility:	Rose Home
Facility Address:	308 Ireland Auburn, MI 48611
Facility Telephone #:	(989) 662-4595
Original Issuance Date:	10/01/2018
License Status:	REGULAR
Effective Date:	04/01/2023
Expiration Date:	03/31/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 03/28/24, staff Tina Anderson gave Resident A the wrong insulin medication.	Yes

III. METHODOLOGY

04/04/2024	Special Investigation Intake 2024A0872031
04/05/2024	Special Investigation Initiated - Letter
04/05/2024	APS Referral I made an APS referral via email
04/05/2024	Contact - Document Sent I emailed the licensee designee and the administrator requesting information related to this complaint
04/18/2024	Inspection Completed On-site Unannounced
05/07/2024	Contact - Telephone call received Received a call from the home manager, Robin Lintern
05/08/2024	Contact - Face to Face I interviewed Resident A via zoom
05/14/2024	Exit Conference I conducted an exit conference with the licensee designee, James Pilot
05/14/2024	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: On 03/28/24, staff Tina Anderson gave Resident A the wrong insulin medication.

INVESTIGATION: On 04/17/24, I reviewed Adult Foster Care documentation regarding this complaint. According to the Incident/Accident Report (IR) dated 03/28/24 completed by staff, Tina Anderson, “(Resident A’s) blood sugar was 347, so I called the nurse. Spoke with Nurse Linda. She said to go ahead and give her meds. I gave her Latuda.

And then somehow, I grabbed (Resident B's) HumaLog and gave it to (Resident A.)" Staff Anderson called Nurse Linda back and told her about the medication error. Nurse Linda told staff to take Resident A's blood sugar again in one hour. If it is under 100, Staff Anderson is supposed to call Nurse Linda back but if not, Resident A would be fine.

Resident A complained of chest pain later that night, so she was transported to the hospital and kept for observation. She was diagnosed with non-specific chest pain/anxiety. The corrective measures taken were staff notified the home manager that Resident B's HumaLog is now eight units short, and Staff Anderson is taking a med class refresher.

I reviewed Resident A's medication list and noted that she is prescribed Latuda (Lurasidone) but is not prescribed HumaLog. According to her medication log, she is diagnosed with hypertension, diabetes mellitus, hypothyroidism, intellectual disability, morbid obesity, mixed bipolar affective disorder, mixed dyslipidemia, and borderline personality disorder. I reviewed Resident A's Health Care Appraisal (HCA) dated 7/31/23. The HCA does not specify Resident A's diagnoses but does state that she should be provided with a low carb diet for diabetes.

On 04/18/24, I conducted an unannounced onsite inspection of Rose Home AFC. I interviewed the home manager (HM), Robin Lintern and observed two residents who were clean, dressed appropriately, and were being supervised by staff. HM Lintern confirmed that on 03/28/24, Resident A was administered the wrong medication. According to HM Lintern, Resident A experienced an anxiety episode later that night, so she was transported to McLaren Hospital and was kept for observation. HM Lintern said that Resident A did not experience any ill effects from ingesting the wrong medication.

According to HM Lintern, a few days ago Resident A was expressing suicidal ideation, so she was sent to McLaren Hospital. From there, she was taken to an inpatient psychiatric hospital in Detroit, MI and her discharge date is unknown at this time. HM Lintern agreed to contact me when Resident A returns to the facility.

On 05/07/24, I received a telephone call from HM Lintern. She said that Resident A has returned to the facility. She also said that the facility is currently in quarantine due to a positive Covid diagnosis with one of the residents. We scheduled a Zoom meeting for 05/08/24.

On 05/08/24, I conducted a face-to-face interview with Resident A via Zoom. Resident A told me that she has lived at this facility for three years and she confirmed that she suffers from diabetes. I reviewed the allegations with Resident A, and she confirmed that on one occasion, staff administered her the wrong insulin medication. According to Resident A, this is the only time she is aware of that staff administered her the wrong medication. She told me that "staff stays on top of it" regarding her diabetes. She said that she takes three different types of insulin for diabetes and staff makes sure they

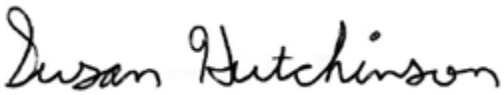
check her blood sugar as they are supposed to. Resident A said that she has not had any issues with medications since that incident.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	According to the Incident/Accident Report (IR) dated 03/28/24, staff Tina Anderson administered Resident A the wrong insulin medication. She administered Resident A HumaLog rather than Latuda. According to Resident A's medication list, she is prescribed Latuda but is not prescribed HumaLog. Home Manager, Robin Lintern confirmed that on 03/28/24, staff Tina Anderson administered Resident A the wrong insulin medication. Resident A confirmed that on one occasion, staff administered her the wrong insulin medication. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 05/14/24, I conducted an exit conference with the licensee designee (LD), James Pilot. I discussed the results of my investigation and explained which rule violation I am substantiating. LD Pilot agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

IV. RECOMMENDATION

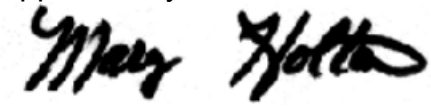
Upon the receipt of a corrective action plan, I recommend no change in the license status.



May 14, 2024

Susan Hutchinson Licensing Consultant	Date

Approved By:



May 16, 2024

Mary E. Holton Area Manager	Date