GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 28, 2024

Geralyn Wright
Wright's Compassionate Care, Inc.
3510 E. Carpenter Rd.
Flint, MI 48506

RE: License #:	AS250378488
Investigation #:	2024A0872033
	Geralyn's Assisted Living

Dear Geralyn Wright:

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 #:	AS250378488
Investigation #:	2024A0872033
Complaint Receipt Date:	04/11/2024
Investigation Initiation Date:	04/11/2024
Report Due Date:	06/10/2024
Licensee Name:	Wright's Compassionate Care, Inc.
Licensee Address:	3510 E. Carpenter Rd. Flint, MI 48506
Licensee Telephone #:	(810) 394-6955
Administrator:	Geralyn Wright
Licensee Designee:	Geralyn Wright
Name of Facility:	Geralyn's Assisted Living
Facility Address:	3510 E. Carpenter Rd. Flint, MI 48506
Facility Telephone #:	(810) 394-6955
Original Issuance Date:	10/06/2016
License Status:	REGULAR
Effective Date:	04/06/2023
Expiration Date:	04/05/2025
Capacity:	4
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A fell on two separate occasions and staff did not seek medical attention for her. On one occasion she received broken ribs.	No
Staff did not notify Resident A's guardian of incidents involving Resident A in a timely manner.	No
Staff did not contact Resident A's doctor after she ingested the wrong medication.	Yes
On 04/08/24, Resident A ingested the wrong medication.	Yes

III. METHODOLOGY

04/11/2024	Special Investigation Intake 2024A0872033
04/11/2024	Special Investigation Initiated - Letter I received Incident Reports from the licensee designee
04/16/2024	Inspection Completed On-site Unannounced
05/17/2024	Contact - Telephone call made I interviewed Guardian A1
05/21/2024	Contact - Face to Face I interviewed Resident A at Wellbridge of Fenton
05/23/2024	Exit Conference I conducted an exit conference with the licensee designee
05/23/2024	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: Resident A fell on two separate occasions and staff did not seek medical attention for her. On one occasion she received broken ribs.

INVESTIGATION: On 04/16/24, I conducted an unannounced onsite inspection of Geralyn's Assisted Living Adult Foster Care facility. I interviewed the licensee designee (LD), Geralyn Wright, and live-in-staff (LIS), Dave Shiel.

LD Wright and LIS Shiel confirmed that Resident A had two falls, within a few days of each other. LD Wright said that after Resident A's first fall on 04/09/24, she contacted Resident A's doctor. Resident A's doctor also spoke to Resident A. LD Wright said that Resident A did not receive any injuries from the fall, so after talking to Resident A's doctor, she did not seek outside medical attention for her. LD Wright said that she did not complete an Incident/Accident Report after this fall and she did not document her conversation with Resident A's doctor.

LD Wright said that on 04/12/24, Resident A suffered another fall. LD Wright was unable to get Resident A back to her feet and she was concerned that she experienced another fall. LD Wright contacted 911 and paramedics transported Resident A to Genesys Medical Center. LD Wright said that Resident A is still at a rehabilitation center so she can be evaluated due to her falls. LD Wright told me that Resident A did not receive any injuries from the fall, and she did not have broken ribs.

According to Resident A's Assessment Plan, she is fully ambulatory. She does not require staff assistance with bathing, toileting, or any other personal care needs and she does not have any assistive devices. Resident A's Assessment Plan does not state that she has a history of falls.

On 05/17/24, I interviewed Guardian A1 via telephone. According to Guardian A1, when Resident A moved into Geralyn's Assisted Living AFC, she was completely ambulatory, and she did not have a history of falls. However, while residing at this facility, Resident A fell on two separate occasions, both within short time frames. After Resident A's second fall, she was transported to the hospital and was kept for observation. When she was ready for discharge, she needed rehabilitation, so she was sent to Wellbridge of Fenton which is where she currently resides. Guardian A1 said that Resident A did not receive any broken ribs from the fall.

On 05/21/24, I conducted a face-to-face interview with Resident A at Wellbridge of Fenton. Resident A confirmed that after her fall on 04/12/24, she was transported to the hospital for observation. She said that she did not receive any injuries from the fall, and she did not have broken ribs. Resident A confirmed that she is at Wellbridge of Fenton for rehabilitation services. She said that her doctor determined that her blood pressure medication was affecting her memory, speech, and balance and she now ambulates with a walker. Resident A told me that her guardian is finding a new placement for her because LD Wright said that she cannot take care of her anymore.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	On 04/09/24, Resident A fell but she did not receive any injuries, so LD Wright did not feel Resident A needed outside medical attention. On 04/12/24, Resident A again suffered a fall. LD Wright contacted an ambulance and Resident A was transported to Genesys Medical Center. I conclude that there is insufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Staff did not notify Resident A's guardian of incidents involving Resident A in a timely manner.

INVESTIGATION: On 04/16/24, I conducted an unannounced onsite inspection of Geralyn's Assisted Living Adult Foster Care facility. I interviewed the licensee designee (LD), Geralyn Wright, and live-in-staff (LIS), Dave Shiel.

LD Wright and LIS Shiel told me that on 04/08/24, Resident A ingested the wrong medication. LD Wright said that she notified Resident A's guardian of the medication error on 04/09/24. According to the IR dated 04/08/24, LD Wright notified Guardian A1 of the medication error on 04/09/24 at 11:30am.

LD Wright and LIS Shiel confirmed that Resident A had a fall on 04/09/24 and again on 04/12/24. LD Wright said that she did not notify Resident A's guardian of the fall on 04/09/24 because Resident A said she was "fine" and did not need medical attention. LD Wright said that after Resident A's fall on 04/12/24, she did notify Guardian A1. According to the IR dated 04/12/24, LD Wright notified Guardian A1 of Resident A's fall on 04/12/24 at 3:30am.

On 05/17/24, I interviewed Guardian A1 via telephone. Guardian A1 said that she is concerned that staff did not notify her of Resident A's falls in a timely manner and they did not notify her after Resident A ingested the wrong medication until the next day.

APPLICABLE RULE	
R 400.14311	**Incident notification, incident records.**
	(1) If a resident has a representative identified in writing on the resident's care agreement, a licensee shall report to

	the resident's representative within 48 hours after any of the following: **(a) Unexpected or unnatural death of a resident.** **(b) Unexpected and preventable inpatient hospital admission.** **(c) Physical hostility or self-inflicted harm or harm to others resulting in injury that requires outside medical attention or law enforcement involvement.** **(d) Natural disaster or fire that results in evacuation of residents or discontinuation of services greater than 24 hours.** **(e) Elopement from the home if the resident's whereabouts is unknown.**
ANALYSIS:	LD Wright said that Resident A ingested the wrong medication on 04/08/24 and she notified Guardian A1 on 04/09/24. Guardian A1 said that LD Wright did not notify her about Resident A ingesting the wrong medication until the next day. LD Wright said that Resident A fell on 04/12/24 and was transported to the hospital. According to the IR dated 04/12/24, LD Wright notified Guardian A1 on 04/12/24 at 3:30am. Guardian A1 also said that LD Wright did not notify her of Resident A's falls in a timely manner. I conclude that there is insufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Staff did not contact Resident A's doctor after she ingested the wrong medication.

INVESTIGATION: On 04/16/24, I conducted an unannounced onsite inspection of Geralyn's Assisted Living Adult Foster Care facility. I interviewed the licensee designee (LD), Geralyn Wright, and live-in-staff (LIS), Dave Shiel.

LD Wright and LIS Shiel stated that on 04/08/24, after Resident A ingested the wrong medication, they did not contact Resident A's doctor or poison control, but they did observe Resident A throughout the night. LD Wright said that she did contact Resident A's doctor the next day. According to the IR, Resident A ingested the wrong medication on 04/08/24 at 8:30pm but Resident A's doctor was not contacted until on 04/09/24 at 3:30pm.

On 05/17/24, I interviewed Guardian A1 via telephone. Guardian A1 said that she is concerned that staff did not contact Resident A's doctor immediately after learning that Resident A ingested the wrong medication.

On 05/21/14, I conducted a face-to-face interview with Resident A at Wellbridge of Fenton. She confirmed that LD Wright and LIS Shiel were aware that she ingested the wrong medication sometime last month. I asked her if anyone contacted her doctor or poison control, and she said no. I asked her when she was seen by a doctor, and she said no. According to Resident A, a couple hours after ingesting the wrong medications, she started "feeling funny." Resident A said that she asked LD Wright to call an ambulance, but she would not so Resident A called Relative A1. Resident A said that while talking to Relative A1, she was slurring her words so Relative A1 called the facility. However, while LD Wright was talking to Relative A1, the phone got disconnected. Resident A said that she does not recall talking a doctor or receiving medical care after this incident but said that she eventually felt better.

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: **(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.**
ANALYSIS:	On 04/08/24, Resident A ingested the wrong medication. According to LD Wright, LIS Shiel, Guardian A1, and Resident A, staff did not contact poison control or Resident A's doctor after discovering the medication error. Resident A said that she told LD Wright that she was "feeling funny" and asked her to contact 911, but LD Wright did not contact the doctor until the next day. According to the IR, Resident A ingested the wrong medication on 04/08/24 at 8:30pm and LD Wright did not notify Resident A's doctor until 04/09/24 at 3:30pm. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: On 04/08/24, Resident A ingested the wrong medication.

INVESTIGATION: On 04/16/24, I conducted an unannounced onsite inspection of Geralyn's Assisted Living Adult Foster Care facility. I interviewed the licensee designee (LD), Geralyn Wright, and live-in-staff (LIS), Dave Shiel. I also obtained AFC paperwork related to this complaint.

LD Wright and LIS Shiel confirmed that on one occasion earlier this month, Resident A was given the wrong medication by LIS Shiel. According to LIS Shiel, he was preparing to pass nighttime medications to three of the residents. He put each resident's medication in a colored shot glass that is specific to each resident and put the shot glasses of medications on top of the locked medication cabinet. He left the room to use the bathroom before passing the medications. When he came back into the room, Resident B said, "She took my meds." LIS Shiel said that he was only gone for a couple of minutes and said that Resident A knew which shot glass was hers, so he does not know why she took the wrong medications. According to LD Wright and LIS Shiel, the next morning they called Resident A's doctor who spoke to Resident A. All decided that she did not need medical treatment due to receiving the wrong medications.

Resident A was not at the facility during this inspection, so I was unable to interview her. I did observe one other resident who appeared clean, dressed appropriately, and was properly supervised by staff.

On 05/17/24, I reviewed AFC paperwork related to this complaint. According to the Incident/Accident Report dated 04/08/24 at 8:30pm, LIS Shiel got Resident B's medication ready and left the room to use the bathroom. When he came back, Resident B told him that Resident A took her medication. Resident A called her brother who then called 911. The police came to the facility but did not make a report. LD Wright and LIS Shiel noted which medications Resident A ingested. They monitored Resident A throughout the night and called Resident A's doctor and Guardian A1 the next day. The corrective measures taken were, "Do not set meds down at all—even to pee, lock back up, readminister."

On 05/17/24, I interviewed Guardian A1 via telephone. Guardian A1 confirmed that on 04/08/24, Resident A ingested another resident's medication. Guardian A1 said that currently, Resident A resides at Wellbridge of Fenton, and she will not be returning to Geralyn's Assisted Living AFC.

On 05/21/24, I conducted a face-to-face interview with Resident A at Wellbridge of Fenton. Resident A confirmed that she resided at Geralyn's Assisted Living for over a year. She also confirmed that one day last month, she ingested the wrong medication. According to Resident A, there were three medication cups full of medications, sitting on top of the medication cabinet in the dining room. She went into the room, grabbed one of the medication cups, and ingested them. Right after she took them, Resident B said, "Hey! You just took my meds!" Resident A told me that shortly thereafter, LIS Shiel came into the room and discovered that she had taken the wrong medication.

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:	On 04/08/24, Resident A ingested Resident B's medication. According to LIS Shiel, LD Wright, and Resident A, the filled medication cups were sitting on top of the medication cart in the dining room. LIS Shiel said that he left the room to go to the bathroom and when he returned, Resident A and Resident B told him that Resident A ingested the wrong medications. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 05/23/24, I conducted an exit conference with the licensee designee, Geralyn Wright. I discussed the results of my investigation and explained which rule violations I am substantiating. LD Wright agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

IV. RECOMMENDATION

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

Susan Hutchinson May 28, 2024

Susan Hutchinson Licensing Consultant	Date

Approved By:

Mary Holton May 28, 2024

Mary E. Holton Area Manager	Date