GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 24, 2024

Melanie Love
Alternative Community Living, Inc.
P. O. Box 190179
Burton, MI 48519

RE: License #: AS250397768
Investigation #: 2024A0569050
New Center

Dear Melanie Love:

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,

Kent W Gieselman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 931-1092

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250397768
Investigation #:	2024A0569050
Complaint Receipt Date:	08/16/2024
Investigation Initiation Date:	08/21/2024
Report Due Date:	10/15/2024
Licensee Name:	Alternative Community Living, Inc.
Licensee Address:	P. O. Box 190179 Burton, MI 48519
Licensee Telephone #:	(248) 505-1987
Administrator:	Melanie Love
Licensee Designee:	Melanie Love
Name of Facility:	New Center
Facility Address:	1921 Colchester Rd Flint, MI 48503
Facility Telephone #:	(810) 265-6040
Original Issuance Date:	06/20/2019
License Status:	REGULAR
Effective Date:	12/20/2023
Expiration Date:	12/19/2025
Capacity:	6
Program Type:	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Medication was observed to be missing on 8/15/24.	Yes

III. METHODOLOGY

08/16/2024	Special Investigation Intake 2024A0569050
08/21/2024	APS Referral Referral to APS.
08/21/2024	Special Investigation Initiated - Letter Email to APS.
09/24/2024	Inspection Completed On-site
09/24/2024	Contact - Telephone call made Contact with Ardis Bates, RRO.
09/24/2024	Contact - Telephone call made Contact with Melonie Love, licensee designee.
09/24/2024	Inspection Completed-BCAL Full Compliance
09/24/2024	Exit Conference Exit conference with Melanie Love, licensee designee.

ALLEGATION:

Medication was observed to be missing on 8/15/24.

INVESTIGATION:

This complaint was received via the on-line complaint portal. The complainant reported that Resident A has a prescription for Ativan that was delivered to the facility on 8/7/0224. The complainant reported that the bubble pack of the Ativan was observed to be missing from the locked medication cart on 8/15/2024. The complainant reported that it is unknown what happened with the bubble pack.

An unannounced inspection of this facility was conducted on 9/24/2024. Resident A was observed to be alert and oriented. Resident A was appropriately groomed and dressed with no visible injuries. Resident A stated that she has not missed a dose of her Ativan. Resident A stated that she was not aware that any of her medication was missing.

On 9/24/2024, the facility medication cart was observed to be locked. Resident A's current medications were observed, and a bubble pack with Ativan was observed in the medication cart prescribed to Resident A. Resident A's medication administration record (MAR) for August and September 2024 was reviewed. Resident A's MAR documents that Resident A has not missed a dosage of the medication.

Kelly Compain, facility manager, stated on 9/24/2024 that Resident A's medication was delivered to the facility on 8/7/2024 along with other resident medications. Kelly Compain stated that Resident A still had more than a week worth of the Ativan left in her bubble pack, so the new bubble pack was locked in a drawer of the medication cabinet. Kelly Compain stated that on 8/15/2024 Resident A had two days' worth of the medication left, so staff started looking for the new bubble pack and realized that the new pack was not in the medication cabinet. Kelly Compain stated that she immediately called the police and filed a report as well as searching all of the drawers of the cabinet. Kelly Compain stated that the bubble pack was never located but the pharmacy replaced the medication on the same day, 8/15/2024, so Resident A never missed a dose. Kelly Compain stated that she does not have any information or evidence that the missing medication was taken by anyone. Kelly Compain stated that during the period that the current bubble pack was still being used, there were several empty bubble packs in one of the drawers that were cleared out and thrown away. Kelly Compain stated that it is possible that the missing bubble pack was accidentally thrown away when the empty packs were discarded. Kelly Compain stated that all of the staff have been re-trained in medication administration and making sure medications are not accidentally discarded.

Marla Lymon, staff person, stated on 9/24/2024 that she observed the missing bubble pack in the medication cabinet when it was delivered on 8/7/2024. Marla Lymon stated that Resident A's current bubble pack had not been completely used, so the new bubble

pack was locked in a drawer until it was needed. Marla Lymon stated that the bubble pack was then discovered missing on 8/15/2024. Marla Lymon stated that she did not take the medication and has not heard anyone else talk about taking the medication. Marla Lymon stated that the missing bubble pack was replaced by the pharmacy before Resident A ran out of the medication, so Resident A never missed a dosage.

Kean Pitts, staff person, stated on 9/24/2024 that Resident A's new bubble pack of Ativan was delivered by the pharmacy and placed into a locked drawer in the medication cabinet. Kean Pitts stated that he does not know what happened to the new bubble pack and that he did not take the bubble pack. Kean Pitts stated that Resident A did not miss a dose and that the pharmacy replaced the medication the same day it was observed missing.

Ardis Bates, Shiawassee County recipient rights officer, stated on 9/24/2024 that she investigated this complaint. Ardis Bates stated that she did not find any evidence to suggest that the medication was stolen by staff or other residents. Ardis Bates stated that she believes that the bubble pack was accidentally thrown away with other empty bubble packs. Ardis Bates stated that she did not cite any recipient rights violations.

Melanie Love, licensee designee, stated on 9/24/2024 that the missing medication was reported to her on 8/15/2024 by Kelly Compain. Melanie Love stated that she has found no evidence to suggest the medication was stolen by anyone. Melanie love stated that she believes that the bubble pack was accidentally thrown away.

An incident report (IR) was completed on 8/15/2024 by Kelly Compain. The IR documents that the bubble pack was observed missing on 8/15/2024 when Resident A's current bubble pack had two days' worth of the medication left. The IR documents that she immediately searched through all of the drawers of the medication cabinet to see if the medication had been misplaced but was not located. The IR documents that a police report was made with the Flint City Police (complaint #24-302255). The corrective measures included contacting the pharmacy to replace the missing medication and do a medication count daily.

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:	Resident A's Ativan bubble pack was observed missing from the medication cabinet on 8/15/24. All of the staff have stated that they do not know what happened to the bubble pack, but that they did not take the medication. During the period beginning

	when the medication was delivered to when it was needed, several other empty bubble packs were discarded. Ardis Bates stated that she believes the missing medication was accidentally thrown away with the empty bubble packs. The bubble pack was then replaced on 8/15/24 and Resident A did not miss a dose of the medication. Based on the statements given and documents reviewed, the bubble pack of Ativan, a highly addictive narcotic, has gone missing and not been recovered confirming that reasonable precautions were not taken to ensure the medication was not used by a person other than the resident it was prescribed for.
CONCLUSION:	**VIOLATION ESTABLISHED**

An exit conference was conducted with Melanie Love, licensee designee, on 9/24/24. The findings in this report were reviewed.

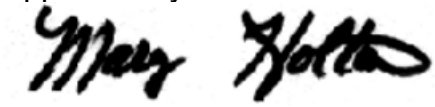
IV. RECOMMENDATION

I recommend that the status of this license remain unchanged upon receipt of an acceptable corrective action plan.

9/24/2024

Kent W Gieselman Date
Licensing Consultant

Approved By:



9/24/2024

Mary E. Holton Date
Area Manager