GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 11, 2024

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

RE: License #:	AS090016193
Investigation #:	2024A0123042
	Kasemeyer

Dear James Pilot:

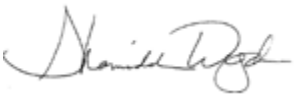
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 E. Genesee Ave.
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS090016193
Investigation #:	2024A0123042
Complaint Receipt Date:	06/07/2024
Investigation Initiation Date:	06/10/2024
Report Due Date:	08/06/2024
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:	Kasemeyer
Facility Address:	5181 Kasemeyer Bay City, MI 48706
Facility Telephone #:	(989) 667-0470
Original Issuance Date:	02/01/1995
License Status:	REGULAR
Effective Date:	10/24/2022
Expiration Date:	10/23/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
• On 5/31/24, staff Kelly Janik passed Resident A's 8:00 pm medications but failed to sign the medications off in the electronic medication record.	Yes
• On 5/31/24, Staff Crystal Clark did not see that the medications were previously passed to Resident A because they were not signed for in the computer. Staff Clark administered Resident A a second dose of medications at 8:30pm. The medication error was discovered on 6/1/24.	Yes

III. METHODOLOGY

06/07/2024	Special Investigation Intake 2024A0123042
06/07/2024	APS Referral Information received regarding APS referral.
06/10/2024	Special Investigation Initiated - Telephone I spoke with recipient rights investigator Kevin Motyka.
06/11/2024	Inspection Completed On-site I conducted an unannounced on-site at the facility.
06/13/2024	Contact - Telephone call made I left a voicemail requesting a return call from staff Crystal Clark.
06/13/2024	Contact - Telephone call made I left a voicemail requesting a return call from Resident A's public guardian, Guardian 1.
06/17/2024	Contact - Telephone call received I received a voicemail from staff Crystal Clark.
06/17/2024	Contact - Telephone call made I made an attempted return call to Staff Clark.
06/26/2024	Contact - Telephone call made I made a second attempt at contacting Guardian 1. There was no answer.
06/26/2024	Contact - Telephone call made I interviewed staff Crystal Clark via phone.

07/11/2024	Exit Conference I conducted an exit conference with administrator/designated person Tammy Unger.

ALLEGATION:

- **On 5/31/24, staff Kelly Janik passed Resident A's 8:00 pm medications but failed to sign the medications off in the electronic medication record.**

- **On 5/31/24, Staff Crystal Clark did not see that the medications were previously passed to Resident A because they were not signed for in the computer. Staff Clark administered Resident A a second dose of medications at 8:30pm. The medication error was discovered on 6/1/24.**

INVESTIGATION: On 06/10/2024, I spoke with recipient rights investigator Kevin Motyka. He stated that he spoke with a Bay Arenac Behavioral Health nurse who informed him that Resident A was put at risk of harm. Resident A was unsteady on their feet, and drowsy. Resident A has a history of falls. Resident A did not fall and has no injuries. The staff that administered the second doses popped pills out of the bubble pack for the next day's pills (06/01/2024).

On 06/11/2024, I conducted an unannounced on-site visit at the facility with Kevin Motyka. Staff Kelly Janik was interviewed. Staff Janik stated that that she worked second shift on 05/31/2024 from 2:00 pm to 8:00 pm. Staff Janik stated that earlier in the evening, another resident had a medical emergency that happened right before Staff Janik was passing medications. Staff Janik stated that she passed Resident A their medications and did not document the med passes. Staff Janik stated that she thought she communicated it with staff Crystal Clark that the medications were passed to two other residents, and Resident A. Staff Janik stated that she did not leave her shift until Staff Clark acknowledged that the medication count at shift change was completed. Staff Janik stated that she reported to work the next morning (on 06/01/2024) and heard staff talking about how Resident A was acting groggy and stumbling, and how the narcotic medication count was off. Staff Janik stated that she pulled Staff Clark to the side and they both realized that they both passed Resident A medications. Staff Janik stated that poison control, the home manager Cassaundra Southgate, and Bay Arenac Behavioral Health nurse Penny Griffus, RN was called.

Resident A was interviewed. Resident A stated that they take whatever their doctor orders, and medications are passed morning, noon, and in the evening. Resident A denied having any issues with their medication.

A copy of the *AFC Licensing Division- Incident/Accident Report* dated 06/01/2024 at 6:01 am written by staff Kelly Janik, and home manager Cassaundra Southgate was received. It states the following under *Explain What Happened*:

"*Upon arrival to work, staff was discussing [Resident A] and how [Resident A] was acting last night, (more drowsy & wobbly than normal) and it was also stated that the narc count on [Resident A's] meds were off last night. It was then discovered that [Resident A's] 8 pm meds had been mistakenly given twice. Outgoing 8 pm staff forgot to submit [Resident A's] 8 pm meds into the computer. Oncoming staff gave a 2nd dose mistakenly at 8:30 pm*."

Under *"Action taken by staff"* it states:

"*Staff called HM as soon as discovery was made. Nurse Penny contacted & instructed to call poison control. Poison Control stated that it had been at least 12 hrs since, that the medications should be out of his system. Stated that [Resident A] may be groggy today. Called Penny back she stated to take vitals and report if anything abnormal. Keep eye on [Resident A] as he maybe groggy & is a high fall risk. PO (physician order) & IR (incident report) done also*."

Under "*Corrective Measures taken to Remedy and/or Prevent Recurrence*" it states:

"*Will contact BABH (Bay Arenac Behavioral Health) S. VanParis for possible med refresher course. Will in-service all staff regarding med passing- making sure to be popping from correct dates. Advise HM when packs are off*."

Copies of Bay Human Services *Employee Corrective Action* documentation was received as well. A written corrective action was completed for staff Crystal Clark and staff Kelly Janik dated 06/03/2024 due to a medication error.

Resident A's medication administration records for May 2024 was reviewed. Staff Kelly Janik's initials are noted for 8:00 pm on 05/31/2024. There are seven different medications noted on the electronic MAR (medication administration record) that are passed daily at 8:00 pm. They are as follows:

- 8 Hour Pain Relief ER (take one table by mouth three times daily)
- Briviact Tab 100 MG (Take one tablet by mouth twice daily)
- Haloperidol Tab 5 MG (take ½ tablet by mouth twice daily)
- Lacosamide Tab 200 MG (Take one tablet by mouth twice daily)
- Lamotrigine Tab 100 MG (Take one tablet by mouth twice daily)
- Lamotrigine Tab 25 MG (Take one tablet by mouth twice daily)
- Trazodone Tab 50 MG (Take one tablet by mouth at bedtime)

A copy of Resident A's *Assessment Plan for AFC Residents* dated 02/28/2024 was obtained. It states that Resident A requires staff assistance with medication administration. It notes "*BHS staff to administer & manage all prescribed meds by Dr*."

On 06/13/2024 and 06/26/2024, phone call attempts were made to contact Resident A's public guardian. A voicemail was left on 06/13/2024. The call was not returned.

On 06/26/2024, I interviewed staff Crystal Clark via phone. Staff Clark stated that she came in for work about 8:00 pm. The second shift staff were behind on medication passing. Staff Clark stated that she received the rundown of who had medications already given to them, and Resident A was not on that list. Resident A's medications were also not signed out in the electronic MAR as passed. Staff Clark stated that the medication error was not caught until the following morning when staff realized the narcotic count was off. Staff Clark stated that Resident A was groggy, and unsteady, but being unsteady is Resident A's normal. Staff Clark stated that this incident has never happened before.

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: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	On 06/11/2024, I conducted an unannounced on-site at the facility with Kevin Motyka of recipient rights. Staff Kelly Janik was interviewed and reported that she did not initial Resident A's 8:00 pm medication passes on 05/31/2024 right after passing the medications to Resident A. Resident A was interviewed during this on-site and denied having any issues with their medication. An *AFC Licensing Division- Incident/Accident Report* dated 06/01/2024 documents that *outgoing 8:00 pm staff forgot to submit Resident A's 8:00 pm meds into the computer.* On 06/26/2024, staff Crystal Clark was interviewed and stated that she was provided a rundown of which residents had received their 8:00 pm medications already and Resident A was not on the list, and that the medications had not being signed out in the electronic MAR.

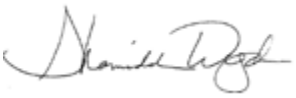
	There is a preponderance of evidence to substantiate a rule violation. Staff Kelly Janik did not sign out Resident A's medications in the electronic medication administration records timely on 06/11/2024.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(a) Medications.**
ANALYSIS:	On 06/11/2024, I conducted an unannounced on-site at the facility with Kevin Motyka of recipient rights. Staff Kelly Janik was interviewed and reported that she did not initial Resident A's 8:00 pm medication passes on 05/31/2024. Resident A was interviewed during this on-site and denied having any issues with their medication. An *AFC Licensing Division- Incident/Accident Report* dated 06/01/2024 documents that staff passed Resident A's 8:00 pm medications on 05/31/2024 twice. On 06/26/2024, staff Crystal Clark was interviewed and stated that she was provided a rundown of which residents had received their 8:00 pm medications already and Resident A was not on the list, and that the medications had not being signed out in the electronic MAR. There is a preponderance of evidence to substantiate a rule violation. Staff Kelly Janik did not sign out Resident A's medications in the electronic medication administration record timely. Staff Crystal Clark subsequently passed Resident A a second dose of his 5/31/2024 8:00 pm medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 07/11/2024, I conducted an exit conference with administrator/designated person Tammy Unger. I informed her of the findings and conclusions.

IV. RECOMMENDATION

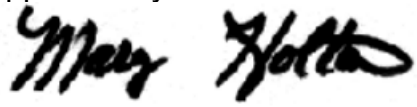
Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC small group home license (capacity 1-6).



07/11/2024

Shamidah Wyden Date
Licensing Consultant

Approved By:



07/11/2024

Mary E. Holton Date
Area Manager