GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 15, 2024

Holly Heath
Community Opportunity Center NPHC
14147 Farmington Rd
Livonia, MI 48154

RE: License #: AL820007566
Investigation #: 2024A0992050
Garden City Opportunity Manor

Dear Holly Heath:

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.

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 (313) 456-0380.

Sincerely,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 300-9922

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL820007566
Investigation #:	2024A0992050
Complaint Receipt Date:	08/27/2024
Investigation Initiation Date:	08/28/2024
Report Due Date:	10/26/2024
Licensee Name:	Community Opportunity Center NPHC
Licensee Address:	14147 Farmington Road Livonia, MI 48154
Licensee Telephone #:	(734) 838-0536
Administrator:	Holly Heath
Licensee Designee:	Holly Heath
Name of Facility:	Garden City Opportunity Manor
Facility Address:	6337 Central Garden City, MI 48135
Facility Telephone #:	(734) 425-0203
Original Issuance Date:	04/19/1985
License Status:	REGULAR
Effective Date:	03/26/2024
Expiration Date:	03/25/2026
Capacity:	15
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Residents medications are missing. Some residents are not getting their medications on time or at all.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/27/2024	Special Investigation Intake 2024A0992050
08/28/2024	Special Investigation Initiated - On Site Home manager, Gretchen Adamaczyk.
08/29/2024	Contact - Telephone call made Licensee designee, Holly Heath, was not available. Message left.
08/30/2024	Contact - Telephone call received Ms. Heath
09/05/2024	Contact - Face to Face Ms. Adamaczyk; and direct care staff Cheryl Ross
09/13/2024	Contact - Telephone call made Ms. Heath was not available. Message left.
09/16/2024	Contact - Face to Face Ms. Adamaczyk, Ms. Ross and Resident B
09/17/2024	Contact - Telephone call received Ms. Heath

ALLEGATION: Residents medications are missing. Some residents are not getting their medications on time or at all.

INVESTIGATION: On 08/28/2024, I completed an unannounced onsite inspection. I interviewed home manager, Gretchen Adamaczyk and observed Resident A. Ms. Adamaczyk confirmed the allegation and stated direct care staff/medication coordinator, Cheryl Ross was responsible for administering medications when the

error occurred. Ms. Adamaczyk stated she discovered the error and immediately reported it to upper management. She stated Ms. Ross was suspended. I observed Resident A exhibiting behaviors including yelling and pacing the area. Ms. Adamaczyk made me aware that the power was out in the facility due to inclement weather and Resident A is not happy. Due to the power outage I agreed to return.

On 08/30/2024, I received a return call from Licensee designee, Holly Heath regarding the allegation. Ms. Heath acknowledged the allegation and confirmed Ms. Ross was suspended from 08/25/2024 through 08/27/2024. Ms. Heath stated traditionally there are two direct care staff on shift. She stated one administers medication and the other double check the medication log to make sure all medications are administered properly. Ms. Heath stated in this instance Ms. Ross was administering medications and Ms. Adamaczyk was checking behind her when she discovered the error. Ms. Heath stated she is in the process of making some changes to prevent medication errors from occurring in the future. I made Ms. Heath aware that I will make follow-up contact with her once the investigation is complete to have an exit conference.

On 09/05/2024, I completed an unannounced onsite inspection and interviewed Ms. Ross regarding the allegation. Ms. Ross stated she typically works from 7:00 a.m. to 3:00 p.m. daily, except for Friday and Saturday. She stated on 08/22/2024, while on transport with Resident B she received a call from Ms. Adamaczyk stating that Residents A and B's medications were not administered and are still in the blister pack. Ms. Ross stated she believe she administered Resident A's medications, but she was also scheduled to transport Resident B to his appointment, so the day was a little rushed. She stated she could not recall if Resident A's medications were given or not. I asked Ms. Ross about normal protocol if she is in the process of administering medication and scheduled for transport, who takes over; she shrugged her shoulders and said, "I don't know." I asked about the ratio of direct care staff scheduled per shift, Ms. Ross said there are two to three staff per shift. She stated staffing depends on the daily operations such as if residents have appointment or other scheduled activities or not. I referenced the cross-check medication process, which Ms. Ross confirmed. She confirmed one staff administer medications and the other staff checks behind them to make sure all medications are administered properly. I asked if the log to confirm the cross-check was completed, and she said yes. Ms. Ross provided me with a log, "medication shift check off sheet" that contained three columns per shift. The columns were labeled, "all med cards checked," "all med sheets signed," and staff initials. The staff that completes the sheet input "yes or no" if the task is completed or not. I asked Ms. Ross if the staff checks "no" the medications sheets were not signed, what is the next step; she shrugged her shoulders and said, "I don't know."

I reviewed the residents MARS and observed the following:
On 08/21/2024, Resident A's Naltrexone HCL 50MG PO TAB, take 3 tablets by mouth twice a day was not initialed.

On 08/22/2024, Resident D's Ditropan Oxybutynin Chloride 5MG PO TAB, take 1 tablet by mouth twice daily was not initialed at 7:30 a.m.

I referenced the "medication shift check off sheet" and asked Ms. Adamaczyk if the staff checks "no" the medications sheets were not signed, what is the next step. She stated the staff checking the log will leave a note for Ms. Ross stating the medications were not initialed and Ms. Ross will go back and initial the medication administration records (MARs). I explained to Ms. Adamaczyk that the person who administers the medication, is supposed to initial the MARs at the time the medication is given.

On 09/16/2024, I interviewed Resident C and asked if he receive his medications daily, Resident C said yes. I asked if the staff administers his medication regularly, and he said no. He stated he takes his own medications every morning at 7:00 a.m. and that he does not take medication at night. Resident C proceeded to his bathroom and obtained a weekly medication case with medication in it. He stated the staff only gives him his cream, but he takes his own pills.

I ask Ms. Adamaczyk about Resident C having access to his medication. Ms. Adamaczyk stated the staff prepares Resident C's medication weekly and he takes it himself. She stated she has been working along with Resident C's supports coordinator, Belinda Pritchet and it is outlined in his individual plan of service (IPOS). I reviewed Resident C's IPOS, which states "Staff will set up my medication as prescribed and prepare for me to administer to myself. Staff will maintain safe administration of all medications and/or treatment and management of disease processes as prescribed. Staff will monitor me for health and safety during medication administration. Staff will administer medication as prescribed and document on my medications chart." Based on the IPOS instructions, I made Ms. Adamaczyk aware it is not possible for the staff to monitor Resident C for health and safety during medication administration if he is administering his own medications in the privacy of his own room. It is not possible for staff to document the medication was administered if staff does not observe Resident C take his medication. I stated it appears the IPOS was misinterpreted. I explained that all resident's medication must be kept in a locked cabinet or drawer.

On 09/17/2024, I conducted an exit conference with Ms. Heath. I explained that based on the findings there is sufficient evidence to support the allegation. I explained that during the investigation I reviewed the MARs and discovered Resident A and Resident D's medications were not initialed. Also, I made Ms. Heath aware that once the staff completes the "medication shift check off sheet" if it is discovered that staff forgot to initial, a note is left for Ms. Ross, and she goes back and initial the medication. I explained that the person who administers the medication, is supposed to initial the MARs at the time the medication is given, which Ms. Heath confirmed. I made Ms. Heath aware that there is an additional finding. I explained that Resident C has his medications in his possession and administered his own medication daily. I explained that all resident's medication

must be kept in a locked cabinet or drawer. Ms. Heath stated she will review the information, and it is possible additional disciplinary actions will be taken. She stated she has implemented changes in the medication process and appointed a second medication coordinator to assist with operations. She said she intends to implement additional structural changes to improve the overall operation.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	During my investigation, which consisted of multiple interviews with licensee designee; direct care staff; Resident C and reviewing pertinent documentation relevant to this investigation, there is evidence to substantiate the allegation that the direct care staff did not administer the medication pursuant to label instructions.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**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:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**

ANALYSIS:	During my investigation, which consisted of multiple interviews with licensee designee; direct care staff; Resident C and reviewing the medication administration records, there is evidence to substantiate the allegation that the direct care staff who administered the medication, did not initial the MARs at the time the medication is given.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 09/16/2024, I interviewed Resident C and asked if he receives his medications daily, Resident C said yes. I asked if the staff administers his medication regularly, and he said no. He stated he takes his own medications every morning at 7:00 a.m. and that he does not take medication at night. Resident C proceeded to his bathroom and obtained a weekly medication case with medication in it. He stated the staff only gives him his cream, but he takes his own pills. Ms. Adamaczyk stated the staff prepares Resident C's medication weekly and he takes it himself. She stated she has been working along with Resident C's supports coordinator, Belinda Pritchet and it is outlined in his individual plan of service (IPOS).

APPLICABLE RULE	
R 400.15312	**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 §333.1101 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:	On 09/16/2024, I interviewed Resident C and he stated he takes his own medications every morning at 7:00 a.m. and that he does not take medication at night. Resident C proceeded to his bathroom and obtained a weekly medication case with medication in it. Ms. Adamaczyk stated the staff prepares Resident C's medication weekly and he takes them himself daily.

CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend that the status of the license remains the same.

10/11/2024

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Denasha Walker — Date
Licensing Consultant

Approved By:

10/15/2024

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Ardra Hunter — Date
Area Manager