GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 10, 2025

Thomas Quakenbush
Community Homes Inc
3925 Rochester Rd.
Royal Oak, MI 48073

RE: License #: AS630012406
Investigation #: 2025A0465009
Community Homes Inc AFC Home

Dear Mr. Quakenbush:

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 (248) 975-5053.

Sincerely,

Stephanie Gonzalez, LCSW
Adult Foster Care Licensing Consultant
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Cadillac Place, Ste 9-100
Detroit, MI 48202
Cell: 248-308-6012
Fax: 517-763-0204

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630012406
Investigation #:	2025A0465009
Complaint Receipt Date:	12/11/2024
Investigation Initiation Date:	12/11/2024
Report Due Date:	02/09/2025
Licensee Name:	Community Homes Inc
Licensee Address:	3925 Rochester Rd. Royal Oak, MI 48073
Licensee Telephone #:	(248) 336-0007
Administrator:	Thomas Quakenbush
Licensee Designee:	Thomas Quakenbush
Name of Facility:	Community Homes Inc AFC Home
Facility Address:	2503 W 14 Mile Road Royal Oak, MI 48073
Facility Telephone #:	(248) 549-3928
Original Issuance Date:	N/A
License Status:	REGULAR
Effective Date:	10/12/2023
Expiration Date:	10/11/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Direct care staff, Donna Giannini, improperly administered Resident A's Guanfacine medication from 11/21/2024 – 11/23/2024.	Yes

III. METHODOLOGY

12/11/2024	Special Investigation Intake 2025A0465009
12/11/2024	APS Referral Adult Protective Services (APS) referral - denied
12/11/2024	Special Investigation Initiated - Letter Email exchange with Complainant
12/17/2024	Inspection Completed On-site I completed an onsite inspection of the facility. I completed a walk-through of the home, observed residents, reviewed resident files and interviewed direct care staff, Dawn Turner
01/03/2025	Contact - Document Received Facility documents received via email
01/16/2025	Contact - Telephone call made I called direct care staff, Donna Giannini. Requested return call
01/22/2025	Contact - Telephone call made I spoke to Guardian A1 via telephone
01/29/2025	Contact - Document Received Facility documents receive via email
01/30/2025	Contact - Telephone call made I called direct care staff, Donna Giannini. Requested return call
02/03/2025	Exit Conference I conducted an Exit Conference with licensee designee/administrator, Thomas Quakenbush, via telephone

ALLEGATION:

Direct care staff, Donna Giannini, improperly administered Resident A's Guanfacine medication from 11/21/2024 – 11/23/2024.

INVESTIGATION:

On 12/11/2024, a complaint was received, alleging the following: direct care staff, Donna Giannini, improperly administered Resident A's Guanfacine medication from 11/21/2024 – 11/23/2024. The complaint stated that Resident A's Guanfacine medication dosage was changed in November 2024. The complaint stated that Ms. Giannini did not discontinue the old medication, but rather administered both the old dosage and the new dosage to Resident A from 11/21/2024 – 11/23/2024.

On 12/11/2024, I spoke to Complainant via email exchange. Complainant confirmed that the information contained in this complaint is accurate.

On 12/17/2024, I completed an onsite inspection of the facility. The home specializes in caring for individuals with developmental disabilities and cognitive/verbal limitations. At the time of my onsite investigation, there were six residents residing in the home. Due to the medical diagnosis and limited verbal abilities of the residents, I was unable to interview them as part of this investigation. I observed all residents to be properly dressed and with adequate hygiene. I did not observe any concerns. I completed a walk-through of the home, observed residents, reviewed resident files, and interviewed direct care staff, Dawn Turner and Vertis Gardner.

I reviewed Resident A's record. The *Face Sheet* stated that Resident A was 3/15/2012 and has a legal guardian, Guardian A1. The *Health Care Appraisal* listed Resident A medical diagnosis as Down Syndrome. The Assessment Plan for AFC Residents stated that Resident A requires supervision in the community, limited verbal communication, is not alert to surroundings, has no concept of time, has a history of aggressive behavior, needs assistance with self-care tasks and does not require use of assistive devices for mobility.

I reviewed the *Medication Administration Record* for November 2024, which documented that Resident A was administered Guanfacine 3mg and Guanfacine 4mg on 11/20/2024, 11/21/2024, 11/22/2024 and 11/23/2024. The medication prescription order documentation stated that Resident A's Guanfacine medication dosage was changed on 11/20/2024 from 3mg to 4mg, with the 3mg dosage discontinued effective 11/20/2024.

I reviewed the *Incident/Accident Reports,* which stated the following:

> *11/20/2024 at 7:00pm; Completed by Donna Giannini: Staff was passing medication to Resident A. Staff was told Resident A had a new medication. Staff did not notice it*

was one of the same medications in his medication book. Staff is monitoring Resident A and staff called pharmacy. Monitoring for any side effects.

11/23/2024 at 12:00am; Completed by Dawn Turner: Staff (Ms. Giannini) passed 3mg Guanfacine on November 21st, 22nd and 23rd, even after it was discontinued. Will retrain staff on proper procedure on passing medication.

The *Team Member Corrective Action Record*, dated 11/25/2024, stated the following:

Employee Name: Donna Giannini; Received Corrective Action For: Medication Error. On November 21st, 22nd and 23rd, you failed to review medication prescription for Resident A. When passing the normal medication, you passed Resident A's 3mg Guanfacine, then when informed that there was a new medication, you administered without completing the necessary checks and ended up giving an additional 4mg of the Guanfacine, which resulted in giving a double dose. You need to be mindful of the 8 rights of passing medication with completing the three mandatory checks per resident. Moving forward from this, we need to schedule a day and time for you to complete training. Please get back to me for that by 12/6/2024. Ms. Giannini refused to sign the document.

I spoke to direct care staff, Dawn Turner, who stated that she is the home manager for the home. Ms. Turner stated, "Ms. Giannini did improperly pass 7mg of Guanfacine to Resident A in November for several days. Resident A was originally prescribed 3mg of Guanfacine, but on 11/20/2024, a new dosage of Guanfacine 4mg was prescribed. The 3mg dosage was supposed to be discontinued on this same day. When the new medication Guanfacine 4mg arrived at the home. When Ms. Giannini went to administer Resident A's Guanfacine medication, she proceeded to give Resident A both the 4mg and the 3mg dosages, instead of just the 4mg dosage, from 11/20/2024 – 11/23/2024. Ms. Giannini realized she made an error and called me to inform me of this error. I informed her that she needed to call the 24-hour pharmacy to notify them of the error and to find out what needs to be done. Resident A did not suffer any side effects from this error. I also informed Ms. Giannini to complete an incident report. Ms. Giannini agreed to pull the 3mg medication. Ms. Giannini stated that it was an error but refused to sign the corrective action form and was subsequently removed from the facility and is no longer working at the facility.

On 1/22/2025, I spoke to Guardian A1 via telephone. Guardian A1 stated, "Resident A has been residing at the facility for a very long time. I am aware of the medication error, and I think it was an accident. I do not think staff purposely did this. Yes, it was a mistake, but I also think the pharmacy should have taken the discontinued medication at the time that they dropped off the new medication and this is what caused confusion for staff. Resident A is doing very well at the home and is receiving good care." Guardian A1 did not vocalize any concerns related to this complaint.

On 1/16/2025 and 1/30/2025, I attempted to speak to direct care staff, Donna Giannini, via telephone. Ms. Giannini has not returned my calls as of the date of this report.

On 2/32025, I conducted an exit conference with licensee designee/administrator, Thomas Quakenbush, via telephone. Mr. Quakenbush is in agreement with the findings of this report.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	According to the *Medication Administration Record, Incident/ Accident Report, and Team Member Corrective Action Record,* Ms. Giannini admitted that she improperly administered Guanfacine 3mg, to Resident A on 11/20/2024, 11/21/2024, 11/22/2024 and 11/23/2024. According to Ms. Turner, when she spoke to Ms. Giannini via telephone, she acknowledged that she improperly administered Guanfacine 3mg to Resident A from 11/20/2024 – 11/23/2024. Based on the information above, there is sufficient information to confirm that Ms. Giannini improperly administered Resident A's Guanfacine medication from 11/20/2024 – 11/23/2024.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend closure of this special investigation with no change to the status of the license.

Stephanie Gonzalez 2/7/2025

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Stephanie Gonzalez Date
Licensing Consultant

Approved By:

02/10/2025

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Denise Y. Nunn Date
Area Manager