RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

December 21, 2017

Pamela Mohrhardt
Christian Care Assisted Living
1530 McLaughlin Avenue
Muskegon, MI 49442-4191

RE: License #: AH610236765
Investigation #: 2018A1010008
Christian Care Assisted Living

Dear Mrs. Mohrhardt:

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 (616) 356-0183.

Sincerely,

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 260-7781

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH610236765
Investigation #:	2018A1010008
Complaint Receipt Date:	12/18/2017
Investigation Initiation Date:	12/18/2017
Report Due Date:	02/17/2018
Licensee Name:	Christian Care Inc.
Licensee Address:	1530 McLaughlin Ave. Muskegon, MI 49442
Licensee Telephone #:	(231) 722-7165
Administrator:	Pamela Mohrhardt
Authorized Representative:	Pamela Mohrhardt
Name of Facility:	Christian Care Assisted Living
Facility Address:	1530 McLaughlin Avenue Muskegon, MI 49442-4191
Facility Telephone #:	(231) 777-3568
Original Issuance Date:	01/01/2000
License Status:	REGULAR
Effective Date:	07/07/2017
Expiration Date:	07/06/2018
Capacity:	105
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Staff person Treshawna Dixon Stole narcotics and Tylenol with Codeine from residents.	Yes

III. METHODOLOGY

12/18/2017	Special Investigation Intake 2018A1010008
12/18/2017	Special Investigation Initiated - On Site
12/18/2017	Contact - Document Received Received Resident Med Count History documents
12/18/17	Exit Conference
12/19/17	APS Referral APS complaint emailed to Centralized Intake
12/20/2017	Contact telephone call made I contacted Ms. Strand by telephone

ALLEGATION:

Staff person Treshawna Dixon Stole narcotics and Tylenol with Codeine from residents.

INVESTIGATION:

On 10/3/17, I received a telephone call from director of clinical care Lori Strand. Ms. Strand informed me staff at the facility discovered some resident medication packets were tampered with. Ms. Strand stated the police were contacted and an internal investigation at the facility was started. Ms. Strand reported she would submit an incident report after she gathered additional information.

On 11/15/2017, I received an incident report from the facility regarding the medication theft.

On 12/18/17, I reviewed the facility file and the previously submitted incident report. The *Description of unusual Occurrence by Observer(s) [Facts only – No Speculation*

and/or commentary] section of the report read, “Staff observed numerous narcotic cards with tape on the back of them. Investigation revealed pills which were taped in were not narcotics. Pills missing included Norco 10/325, Norco 7.5/325, Norco 5/325, and Tylenol #3 with Codeine. Police called to investigate. Staff member confessed.”

The *Cause (if known)* section of the report read, “Staff member Treshawna Dixon diverted narcotics replacing them with regular Tylenol.”

The incident report also included the police report which I reviewed.

On 12/18/17, I interviewed administrator Pam Mohrhardt at the facility. Ms. Mohrhardt reported staff person Melnischa Broom contacted Ms. Strand on 10/3 to inform her resident medications on the second floor were tampered with. Ms. Mohrhardt stated first shift staff followed the appropriate protocol by not accepting the narcotic count and contacting Ms. Strand to notify her of the situation. Ms. Mohrhardt reported the building was then put on lockdown and the police were contacted. Ms. Mohrhardt stated the officer arrived at the facility and begun an investigation.

Ms. Mohrhardt reported staff person Treshawna Dixon later contacted Ms. Strand and admitted she stole resident medications because “she got into a bad situation.”

On 12/18/17, I interviewed Ms. Strand at the facility. Ms. Strand’s statements were consistent with the incident report, police report, and Ms. Mohrhardt’s statements. Ms. Strand reported it is unknown how long Ms. Dixon was stealing and replacing resident narcotics and Tylenol with Codeine before she was caught. Ms. Strand stated she observed the medication packets that Ms. Dixon tampered with. Ms. Strand reported she observed the regular Tylenol pills Ms. Dixon put in place of the ones she stole.

Ms. Strand reported Resident A was missing 49 Tylenol #3 with codeine pills. Ms. Strand stated this medication was prescribed to Resident A as needed (PRN). Ms. Strand said this medication was not administered to Resident A in November or the beginning or October. Ms. Strand reported it was not likely Resident A received the wrong medication as a result. I reviewed Resident A’s *Med Count History* document to verify Ms. Strand’s statements.

Ms. Strand stated Resident B was missing six Hydrocodone-Acet 5-325 pills. Ms. Strand reported this was a prescribed PRN medication. Prior to 10/3, the last time this medication was administered was on 9/27. I reviewed Resident B’s *Med Count History* document to verify Ms. Strand’s statements.

Ms. Strand reported Resident C was missing 46 Hydrocodone-Acet 10-325 pills. Ms. Strand said this medication was a prescribed PRN medication. Prior to 10/3, the last

time it was administered was on 10/2. I reviewed Resident C's *Med Count History* document to verify Ms. Strand's statements.

Ms. Strand said Resident D was missing 14 Hydrocodone-Acet 10-325 pills. Ms. Strand reported this medication was prescribed to be given four times a day. Prior to 10/3, the last time it was administered was on 10/2. I reviewed Resident D's *Med Count History* document to verify Ms. Strand's statements.

Ms. Strand stated Resident E was missing five Hydrocodone-Acet 5-325 pills. Ms. Strand reported this medication was prescribed to be given every four hours. Prior to 10/3, the last time it was administered was on 10/2.

Ms. Strand Reported Resident F was missing twelve Hydrocodone-Acet 7.5-325 pills. Ms. Strand said this was a prescribed PRN medication. Prior to 10/3, the last time it was administered was 9/13. I reviewed Resident F's *Med Count History* document to verify Ms. Strand's statements.

Ms. Strand said Resident G was missing four Tyelnol #3 with Codeine pills. Ms. Strand reported this was a prescribed PRN medication. Prior to 10/3, the last time it was administered was on 7/17. I reviewed Resident G's *Med Count History* document to verify Ms. Strand's statements.

Ms. Strand stated Ms. Dixon primarily stole PRN medications, therefore the facility does not have a way to verify whether Residents A, B, C, D, E, F, and G received regular Tylenol pills instead of their prescribed medications after Ms. Dixon tampered with them. Ms. Strand reported Ms. Dixon stole the pills in random order to decrease her chance of being caught. Ms. Strand stated the narcotic medication count was never off because Ms. Dixon replaced the pills she stole with regular Tylenol.

Ms. Strand reported she informed the residents' physician regarding the incident. Ms. Strand said the physician was unable to confirm whether or not the residents received the wrong medication after Ms. Dixon tampered with it.

On 12/18/17, I interviewed shift supervisor Rhonda Sullivan at the facility. Ms. Sullivan reported staff approached her regarding the medication packets that were tampered with. Ms. Sullivan stated she observed one of the packets and saw the back had been opened and tapped shut. Ms. Sullivan reported it was clear the medication was tampered with. Ms. Sullivan said she advised the first shift staff not to accept the medication count and call Ms. Strand immediately.

On 12/18/17, I interviewed Resident A at the facility. Resident A reported she enjoyed living at the facility and had no concerns regarding staff. Resident A said she has not had any concerns or known issues regarding staff administering her medications.

On 12/18/17, I interviewed Resident B at the facility. Resident B's statements were consistent with Resident A.

On 12/18/17, I interviewed Resident C at the facility. Resident C's statements were consistent with Residents A and B.

On 12/18/17, I interviewed Resident D at the facility. Resident D's statements were consistent with Residents A, B, and C.

On 12/18/17, I interviewed Resident E at the facility. Resident E's statements were consistent with Residents A, B, C, and D.

On 12/18/17, I interviewed Resident F at the facility. Resident F's statements were consistent with Residents A, B, C, D, and E.

On 12/18/17, I was unable to interview resident G because she no longer resides at the facility.

On 12/19/17, I made an Adult Protective Services (APS) complaint with Centralized Intake.

On 12/20/17, I contacted Ms. Strand by telephone. Ms. Strand stated the facility did not previously have a policy or procedure/training for staff regarding medication that was tampered with. Ms. Strand reported a staff training was held after the incident occurred. Ms. Strand explained the staff training also covered what staff are to do if they accidently puncture a medication pack.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(5) A home shall take reasonable precautions to ensure or assure that prescription medication is not used by a person other than the resident for whom the medication is prescribed.

ANALYSIS:	Interviews with Ms. Mohrhardt, Ms. Strand, and Ms. Sullivan, along with review of the incident and police reports, revealed staff person Treshawna Dixon stole Residents A, B, C, D, E, F, and G's narcotic and Tylenol #3 with codeine medication and replaced the pills with regular Tylenol. Ms. Dixon admitted she tampered with the medication packaging and stole the medication. Staff knowledge that prescription blister packs were, for a period of possibly months, tampered with is evidence of a lack of oversite by the facility and lack of policy that directs staff as to what to do when a blister pack seal has been clearly tampered with.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 12/18/17, I shared the findings of this report with Ms. Mohrhardt at the facility. Ms. Mohrhardt reported a staff in service was held after this incident. Ms. Mohrhardt stated staff who administer medications were trained to closely observe the back of the medication packets when handling resident medications. Ms. Mohrhardt reported Ms. Dixon was also terminated as a result of the incident.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

12/20/17

Lauren Wohlfert — Date
Licensing Staff

Approved By:

12/21/17

Russell B. Misiak — Date
Area Manager