



STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

July 9, 2021

Paula Ott
Central State Community Services, Inc.
Suite 201
2603 W Wackerly Rd
Midland, MI 48640

| | |
|------------------|--------------|
| RE: License #: | AM250083741 |
| Investigation #: | 2021A0123029 |
| | Lara House |

Dear Ms. Ott:

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 (906) 226-4171.

Sincerely,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

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|---------------------------------------|--|
| License #: | AM250083741 |
| Investigation #: | 2021A0123029 |
| Complaint Receipt Date: | 06/10/2021 |
| Investigation Initiation Date: | 06/11/2021 |
| Report Due Date: | 08/09/2021 |
| Licensee Name: | Central State Community Services, Inc. |
| Licensee Address: | Suite 201 2603 W Wackerly Rd Midland, MI 48640 |
| Licensee Telephone #: | (989) 631-6691 |
| Administrator: | Deborah McGuire |
| Licensee Designee: | Paula Ott |
| Name of Facility: | Lara House |
| Facility Address: | 6151 W. Lake Road Clio, MI 48420 |
| Facility Telephone #: | (810) 687-2350 |
| Original Issuance Date: | 06/22/2001 |
| License Status: | REGULAR |
| Effective Date: | 08/01/2020 |
| Expiration Date: | 07/31/2022 |
| Capacity: | 12 |
| Program Type: | DEVELOPMENTALLY DISABLED MENTALLY ILL |

II. ALLEGATION(S)

| | Violation Established? |
|---|-----------------------------------|
| It was discovered that Resident A's Carvedilol 12.5 mg was administered to Resident A on two dates when it should have been held. The medication could have caused physical harm to Resident A. There is a clear guideline that the medication is not to be given to her if her blood pressure is less than 95/55 or if her heart rate is less than 55 BPM. | Yes |

III. METHODOLOGY

| | |
|------------|---|
| 06/10/2021 | Special Investigation Intake 2021A0123029 |
| 06/10/2021 | APS Referral Information received regarding APS referral. |
| 06/11/2021 | Special Investigation Initiated - Telephone I spoke with Pat Shephard of recipient rights via phone. |
| 06/16/2021 | Inspection Completed On-site I conducted an unannounced on-site visit at the facility. |
| 06/25/2021 | Contact - Telephone call made I interviewed staff Tiara Mayfield via phone. |
| 06/25/2021 | Contact - Telephone call made I made an attempted call to Resident A's public guardian. |
| 06/28/2021 | Contact- Telephone call made I made an attempted call to Resident A's public guardian. |
| 07/08/2021 | Contact- Telephone call made I spoke with Resident A's public guardian via phone. |
| 07/09/2021 | Exit Conference- I spoke with Licensee Designee Paula Ott via phone. |

ALLEGATION: It was discovered that Resident A's Carvedilol 12.5 mg was administered to Resident A on two dates when it should have been held. The medication could have caused physical harm to Resident A. There is a clear guideline that the medication is not to be given to her if her blood pressure is less than 95/55 or if her heart rate is less than 55 BPM.

INVESTIGATION: On 06/11/2021, I spoke with recipient rights investigator Pat Shephard via phone. Ms. Shephard stated that a quarterly review was completed and it was discovered that in March 2021, there were two days that Resident A's blood pressure medication should have been held but it was not. She stated that Resident A apparently did not have a reaction to the medication, and she does not think an incident report was written. She stated that she does not think the staff person who administered the medication was aware of the error.

On 06/16/2021, I conducted an unannounced on-site visit to the facility. I spoke with the home manager, Tamika Miller. She stated that staff Tiara Mayfield is the person who made the medication error. She stated that Staff Mayfield quit working at the facility about two weeks ago. She stated that there were no side effects experienced by Resident A as a result of the medication error.

During this on-site, I made a face-to-face visit with Resident A. I attempted to interview Resident A. She stated that she takes medication at 6:00 am, 4:00pm (a blue pill and a white pill), and at 5:00 pm. She stated that she does not know what type of medication she takes.

I observed Resident A's medication during this on-site. They were in bubble packs. I obtained a copy of Resident A's March 2021 medication administration sheet, which says *"take blood pressure hold Carvedilol for BP less than 95/55 or heart rate less than 55."* The documentation confirms that Staff Mayfield passed Resident A's Carvedilol on March 3, 2021, and March 26, 2021, when Resident A's blood pressure was 87/64 and 85/43 respectively.

On 06/25/2021, I interviewed staff Tiara Mayfield via phone. Staff Mayfield stated that she was interviewed regarding this matter by Recipient Rights. She stated that she had made a mistake back in March 2021 where Resident A's blood pressure was low, and she did not catch it. She stated that the mistake was not brought to her attention, until months later. She stated that she no longer works at the facility. She stated that Resident A did not have any side effects.

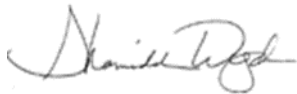
On 07/08/2021, I spoke with Guardian 1, Resident A's public guardian. She stated that she was not aware of the allegations. She denied having any concerns regarding Resident A's care.

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|------------------------|---|
| APPLICABLE RULE | |
| R 400.14312 | Resident medications. |
| | (2) Medication shall be given, taken, or applied pursuant to label instructions. |
| ANALYSIS: | <p>I obtained a copy of Resident A's March 2021 medication administration sheet. The documentation confirms that Staff Mayfield passed Resident A's Carvedilol on March 3, 2021, and March 26, 2021, when Resident A's blood pressure was 87/64 and 85/43 respectively.</p> <p>Staff Mayfield reported that she made a mistake and passed Resident A her medications when she should not have, and that it was not brought to her attention until months later.</p> <p>Guardian 1 denied having any concerns regarding Resident A's care.</p> <p>There is a preponderance of evidence to substantiate a rule violation.</p> |
| CONCLUSION: | VIOLATION ESTABLISHED |

On 07/09/2021, I conducted an exit conference with licensee designee Paula Ott via phone. I informed her of the findings and conclusion.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend continuation of this AFC medium group home license (capacity 12).

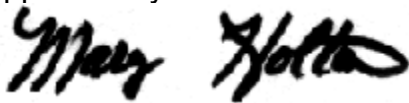


07/09/2021

Shamidah Wyden
Licensing Consultant

Date

Approved By:



07/09/2021

Mary E Holton
Area Manager

Date