GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 6, 2021

Jonathan Harland
Community Home & Health Services LLC
657 Chestnut Ct
Gaylord, MI 49735

RE: License #: AS690382148
Investigation #: 2021A0009027
Pinehaven Red

Dear Mr. Harland:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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 the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- A specific time frame for the 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 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 (231) 922-5309.

Sincerely,

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 350-0939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS690382148
Investigation #:	2021A0009027
Complaint Receipt Date:	06/14/2021
Investigation Initiation Date:	06/14/2021
Report Due Date:	07/14/2021
Licensee Name:	Community Home & Health Services LLC
Licensee Address:	657 Chestnut Ct Gaylord, MI 49735
Licensee Telephone #:	(989) 732-6374
Administrator:	Jonathan Harland
Licensee Designee:	Jonathan Harland
Name of Facility:	Pinehaven Red
Facility Address:	118 McLouth Rd Gaylord, MI 49735
Facility Telephone #:	(989) 732-1614
Original Issuance Date:	05/31/2016
License Status:	REGULAR
Effective Date:	07/02/2019
Expiration Date:	07/01/2021
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Narcotic medication is missing from the facility.	Yes

III. METHODOLOGY

06/14/2021	Special Investigation Intake 2021A0009027
06/14/2021	Special Investigation Initiated – Telephone call to direct care worker Ms. Kayla Frame
06/17/2021	Inspection Completed On-site Interview with home manager Mr. Shawn Goosen Face to face with Resident A
06/29/2021	Contact – Telephone call made to Ms. Amanda Dixon, Community Mental Health (CMH) recipient rights officer
06/29/2021	Contact – Telephone call made to Deputy Keith Sterly, Otsego County Sheriff's Department
06/30/2021	Contact – Telephone call received from Deputy Keith Sterly, Otsego County Sheriff's Department
06/30/2021	Contact – Telephone call made to direct care worker Ms. Kayla Frame
06/30/2021	Contact – Telephone call made to direct care worker Ms. Alicia Schifflet
06/30/2021	Contact – Telephone call made to direct care worker Mr. Cameron Greer, left message
06/30/2021	Contact – Telephone call made to direct care worker Ms. Nelda Nortley
07/01/2021	Contact – Telephone call made to direct care worker Mr. Cameron Greer
07/01/2021	Contact – Telephone call made to direct care worker Ms. Nelda Nortley, no answer

07/02/2021	Exit conference with licensee designee/administrator Mr. Jonathan Harland
07/05/2021	Contact – Telephone call made to direct care worker Ms. Nelda Nortley

ALLEGATION: Narcotic medication is missing from the facility.

INVESTIGATION: On June 14, 2021, I called the main facility telephone number for Pinehaven Red adult foster care (AFC) home. Direct care worker Ms. Kayla Frame answered at that time. She is the home manager for another AFC home within the Community Home & Health Services agency. Ms. Frame explained that she and her staff have been assisting at Pinehaven Red due to a staffing shortage there. Ms. Frame stated that she and her staff initially noticed on June 4, 2021, that Resident A's medication count sheet was missing five or six days of entries prior to June 4, 2021. The missing information was during direct care worker Mr. Cameron Greer's shifts, who works midnights. Ms. Frame said that she mentioned the missing documentation to the home manager Mr. Shawn Goosen. After the weekend, on June 7, 2021, she examined the medication count log again and found that the missing information was filled in. She and her staff also found that six of Resident A's Lorazepam tablets were missing at that time. Ms. Frame contacted an administrator with the Community Home & Health Services agency who also counted the medication. She agreed that six tablets were missing. They contacted law enforcement who did arrive on-site for their own investigation.

I also spoke with licensee designee/administrator Mr. Jonathan Harland by phone on June 14, 2021. He acknowledged that six Lorazepam pills were missing from the facility. According to Mr. Harland they have had staff from another AFC home filling in at Pinehaven Red due to a staffing shortage. Mr. Shawn Goosen is the new home manager at the facility and according to Mr. Harland he has been trying to figure out what happened to the missing medication. Mr. Goosen has the missing medication narrowed down to two to four individuals on staff. He is unable to narrow it down any further than that. Mr. Goosen denied that any of the staff at Pinehaven Red have been acting strangely. Mr. Goosen has set up additional medication training for staff to try to prevent future issues.

I made an unannounced site visit at Pinehaven Red on June 17, 2021. I spoke with home manager Shawn Goosen at that time. He said that Community Mental Health (CMH) recipient rights officer Amanda Dixon informed him that she narrowed the missing medication down to an eight-hour period. Mr. Goosen stated that he did not feel that it could be narrowed down that specifically. He said that he, himself, has narrowed the missing medication down to four staff. Mr. Goosen shared that he is also cooperating with Otsego County Sheriff Deputy Keith Sterly who is investigating the matter. Mr. Goosen stated that he believes that it could also possibly be a medication error. I asked him what kind of mistake would lead to six missing

narcotic pills. He said that it was possible that someone might have accidently dropped the pills in water and then tried to cover up their mistake. He agreed that this was not the most likely scenario. He explained that they do medication counts of medication each time that it is dispensed. The home manager from another facility, Kayla Frame, reportedly told him that the medication count log was missing the medication counts for several days, however, he stated that he did not see this. Resident A's medication log was filled-in by the time he was able to check it. Mr. Goosen stated that Ms. Frame did not write a line through the missing log entries like she should have to prove that they had not been filled in. Ms. Frame also could have made a copy of the missing entries since they do have a copy machine on site. I asked him if there were other instances of direct care worker Cameron Greer not documenting properly. Mr. Goosen stated that Mr. Greer has failed to fill out paperwork before. This included him not filling out a required incident report, not making progress notes and not fulfilling work duties. Mr. Goosen was not aware of Mr. Greer failing to document medication counts before. Staff who dispense medication are also required to count the total amount of medication remaining in the container. They are supposed to document how many pills remain. He said that it is possible for staff to just write down the number that they believe should be left "out of laziness". For instance, looking at the amount that the last staff wrote down and then subtracting the amount that they just dispensed. Mr. Goosen explained that this was why it was difficult to narrow it down to one staff who might have stolen the narcotics. He explained that in the short term, they have put in place a practice for two staff to pass medication together and then sign off that the medication has been passed and counted. He is also providing additional medication pass training to all staff. Mr. Goosen provided me with copies of Resident A's "Daily Medication Count Sheet" for the month of June of 2021.

On June 29, 2021, I spoke with CMH recipient rights officer Ms. Amanda Dixon. She confirmed that she was also involved in the investigation at Pinehaven Red regarding the missing narcotic medication. She said that she believed that the narcotic medication went missing during one of four staff member's shifts. Ms. Dixon explained that she was unable to narrow it down any further than that. She spoke with most of the staff involved. There was no dispute that the pills are missing. Ms. Frame and direct care worker Ms. Alicia Schifflet stated that they "tore apart" the medication room on June 7, 2021, when they discovered that the pills were missing. They found no trace of the Lorazepam pills but did find some Scopolamine patches from another resident which had previously been missing. Ms. Frame and Ms. Schifflet are the ones who reported that they observed missing information in Resident A's medication count log. Ms. Dixon and I discussed Resident A's "Daily Medication Count Sheet" for June of 2021. On the "4p – 12a" sheet, we observed that there was a line drawn through June 6 for the medication counts. Ms. Dixon stated that it was her understanding that Ms. Frame or Ms. Schifflet drew that line through that day to indicate that they found the information missing. I asked Ms. Dixon about a line also being drawn through June 11 when it appeared that medication counts were not made. Ms. Dixon stated that she believed that the same thing happened. There was missing information when Ms.

Dixon and/or Ms. Schifflet came on-shift so they drew a line through the missing information for that shift on June 11, 2021. Ms. Dixon stated that she was recommending to the agency that medication counts be done at shift change between the incoming and outgoing staff.

On June 30, 2021, I received a telephone call from Deputy Keith Sterly with the Otsego County Sheriff's Department. He reported that he did have an open investigation on the matter of the missing narcotics at Pinehaven Red. It had not been narrowed down any further whether any one person took the narcotics. He stated he would continue to investigate the matter if any other evidence came to light.

On June 30, 2021, I spoke with direct care worker/home manager Ms. Kayla Frame. I asked her about the information I received that she and her coworker had searched the medication room on June 7, 2021, looking for the missing narcotics. She agreed that they had. She denied that they found the pills but did find some missing medication patches. Ms. Frame stated that the patches were still in the bag that came from the pharmacy but were found behind the computer. She stated she did not believe that the resident missed a dosage of the patches due to them missing. He gets a new patch every three days. There was no new information regarding the missing Lorazepam pills that she was aware of.

On June 30, 2021, I also spoke with direct care worker Ms. Alicia Schifflet. She said that on June 7, 2021, she and Ms. Frame were counting the residents' medication. She found that Resident A was missing six of his Lorazepam pills. Ms. Schifflet stated that she told Ms. Frame and they both counted them several times and compared the count to what was on the medication count sheet. They looked all over the medication room, behind the counter and desk and on the floor. They did not find the pills. Ms. Schifflet denied that she knew where the pills might be. She denied that she took the pills or accidentally destroyed the pills. She stated that the only thing she could think of was that the midnight shift was not counting the pills accurately but agreed that this would not necessarily result in the pills missing.

On July 1, 2021, I spoke with direct care worker Mr. Cameron Greer. He stated that he worked with Ms. Nelda Nortley on the morning of June 7, 2021. He stated Ms. Nortley was making breakfast while he counted medication. No one else was in the medication room that morning. It was locked when he left so no residents would have been in the room unsupervised. He said that the medication count was "perfect" when he ended his shift at 8:00 a.m. That was when Ms. Frame and Ms. Schifflet came in for their shift. He said that it was his understanding that they did their medication count at 4:00 p.m. and then reported that six pills were missing. Mr. Greer denied that he took the medication or accidentally destroyed the medication. I asked him what he believed happened to the missing pills. He said that his only guess was that one of the staff during the next shift took them. Mr. Greer denied that he ever wrote down a number for a medication count without actually doing the count.

On July 5, 2021, I spoke with direct care worker Nelda Nortley by phone. She denied that she knew anything about the missing narcotic pills. Ms. Nortley denied that she passed medication. She said that she cooked and also cared for the residents' personal needs. She stated that the other staff on duty always gives the residents their medication. Ms. Nortley stated she did not remember anything of note during the days in which the medication reportedly went missing. She denied that any of the staff had been acting strangely that she was aware of. Ms. Nortley also denied taking the medication herself and knew of it being accidently destroyed.

APPLICABLE RULE	
R 400.14312	**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:	It was confirmed through this investigation that medication prescribed to Resident A was not given to him and instead is missing from the facility. If it is lost in some fashion, then it has not been kept in the original pharmacy-supplied container. Other medication has been recently found in the medication room that was previously not accounted for. These were found behind a computer and were not kept in a locked cabinet or drawer.
CONCLUSION:	**VIOLATION ESTABLISHED**

An exit conference was conducted by phone with licensee designee/administrator Mr. Jonathan Harland on July 2, 2021. I told him of the findings of my investigation and gave him the opportunity to ask questions.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change in the license status.

07/06/2021

Adam Robarge — Date
Licensing Consultant

Approved By:

07/06/2021

Jerry Hendrick — Date
Area Manager