GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 20, 2021

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

RE: License #: AS250296942
Investigation #: 2021A0569040
Porter Road Home

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.
- 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 (517) 284-9730.

Sincerely,

Kent W Gieselman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 931-1092

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250296942
Investigation #:	2021A0569040
Complaint Receipt Date:	09/08/2021
Investigation Initiation Date:	09/09/2021
Report Due Date:	11/07/2021
Licensee Name:	Central State Community Services, Inc.
Licensee Address:	Suite 201 2603 W Wackerly Rd Midland, MI 48640
Licensee Telephone #:	(989) 631-6691
Administrator:	Regina Wheaton
Licensee Designee:	Paula Ott
Name of Facility:	Porter Road Home
Facility Address:	7168 Porter Road Grand Blanc, MI 48439
Facility Telephone #:	(810) 695-0018
Original Issuance Date:	03/11/2009
License Status:	REGULAR
Effective Date:	10/04/2019
Expiration Date:	10/03/2021
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

	MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A has poor hygiene.	No
Resident B was not given his medications for 2-3 days.	Yes

III. METHODOLOGY

09/08/2021	Special Investigation Intake 2021A0569040
09/08/2021	APS Referral Complaint received from APS.
09/09/2021	Special Investigation Initiated - Letter Email to ORR.
10/18/2021	Inspection Completed On-site
10/18/2021	Contact- Face to Face Interview with Resident A at her work program.
10/18/2021	Inspection Completed-BCAL Full Compliance
10/18/2021	Exit Conference Exit conference with Regina Wheaton. program manager.
10/19/2021	Contact- document sent Email contact with Jacqueline Williams, APS worker
10/19/2021	Contact- Telephone call made. Contact with Kim Nguyen-Forbes, recipient rights officer.
10/19/2021	Exit conference Exit conference with Paula Ott, licensee designee.

ALLEGATION:

Resident A has poor hygiene.

INVESTIGATION:

This complaint was received from the adult protective services central intake department. The complainant reported that "(Resident A) has a developmental disability and functions at the level of an 8-year-old. (Resident A) also has Parkinson's disease. For the past seven months or so, (Resident A) has been observed in dirty clothing and a strong body odor. (Resident A) also has fungus under her fingernails and toenails so bad to the point where the nails are falling off. The group home staff has been made aware of these concerns multiple times and they still have not done anything about it."

An unannounced inspection of this facility was conducted on 10/18/21. Resident A was not present and was at a work program. Resident A's bedroom was inspected. Resident A's bedroom was clean and sanitized with no foul odor observed. Resident A's clothing and bedding were observed to be laundered and clean. Resident A's file was reviewed. Resident A's file documents that she is her own guardian and that she has not been diagnosed with a developmental disability, but rather, Bi-Polar disorder. Resident A's written assessment documents that she does not require staff assistance with daily hygiene and grooming tasks. Resident A's written assessment also documents that Resident A is capable of moving independently in the community without staff supervision.

Shanita Coleman, facility manager, stated on 10/18/21 that Resident A is capable of completing daily hygiene tasks without staff assistance. Ms. Coleman stated that Resident A does shower on a regular basis and her laundry is done on a weekly basis or more often if needed. Ms. Coleman stated that Resident A will frequently visit a family member (FM1) and when she returns to the facility following a visit, she is often dirty and wearing dirty clothing. Ms. Coleman stated that FM1 frequently comes to the facility and will complain about the way Resident A is cared for. Ms. Coleman stated that FM1 has also requested several times that they be given Resident A's money because they need it, but Resident A is her own guardian, and the money cannot be given to FM1. Ms. Coleman stated that Resident A does not have fungus growing under her nails, but that FM1 wanted Resident A's fingernails to be painted by staff. Ms. Coleman stated that Resident A does not like to paint her fingernails and told staff she did not want her fingernails painted so FM1 became upset about that. Ms. Coleman stated that on another occasion, Resident A went to visit FM1 and FM1 decided that Resident A needed a haircut so FM1 cut Resident A's hair very short and Resident A was upset about the hair cut because she had "long pretty hair" before FM1 cutting it. Ms. Coleman stated that there is no credibility to this allegation.

Resident A was interviewed at her work program on 10/18/21. Resident A was alert and oriented to person, place, and time. Resident A was appropriately dressed and groomed

with no visible injuries. Resident A stated that she is capable of taking showers by herself and does not need staff to assist her. Resident A stated that she is her own guardian. Resident A stated that she feels the staff at this facility provide assistance as needed and that she feels well cared for. Resident A stated that her laundry is done by staff at least once a week. Resident A denied that she is ever prohibited from taking a shower when she wants to.

Jacqueline Williams, APS worker, stated on 10/19/21 that she has made an unannounced visit to this facility on two occasions to meet with Resident A. Ms. Williams stated that Resident A was properly groomed on both occasions and that she has found no evidence to substantiate this allegation. Ms. Williams stated that on one of the visits, Resident A did complain about FM1 cutting her hair but has had no complaints about any of the staff at this facility.

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions, when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	The complainant reported that Resident A has a cognitive disability and has the cognitive ability of an eight-year-old child. The complainant reported that Resident A has very poor hygiene due to staff neglecting her needs. Resident A is her own guardian and does not exhibit a cognitive disability. Resident A's bedroom was observed on 10/18/21 and was clean and sanitized. Resident A's clothing and bedding were also observed to be properly laundered during this inspection. Resident A was observed to be appropriately dressed and groomed on 10/18/21 and stated that she does not require staff assistance to shower or groom. Ms. Williams stated that she has observed Resident A on two occasions and found no evidence to support this allegation. Ms. Coleman stated that Resident A does not have a hygiene problem and does not require staff assistance with grooming. Based on the documentation reviewed, statements given, and observations made, it is determined that there has been no violation of this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident B was not given his medications for 2-3 days.

INVESTIGATION:

The complainant reported that Resident B was admitted to the hospital in August 2021, and when he was released back to the facility on 8/25/21, his medications were changed. The complainant reported that the medication dosages were changed for some of Resident B's medications. The complainant reported that the facility then ran out of Resident B's medications and his prescriptions were not filled until two or three days after the medications had run out. The complainant reported that Resident B did not suffer any side effects or negative reactions to the missed medications.

Resident B was interviewed during the inspection on 10/18/21. Resident B was appropriately dressed and groomed with no visible injuries. Resident B stated that he was having auditory hallucinations and could not recall if he had missed any medications. Resident B presented with rapid speech pattern and exhibited flight of ideas with his speech subject.

Resident B's file was reviewed. Resident B's health care appraisal and psycho-social history document that Resident B has been diagnosed with Schitzo-affective disorder, Resident B's Medication log for August 2021 documents that Resident B was prescribed, in part: **Depakote**- 500mg 1x per day at bedtime, **Clozapine-** 200mg in the morning, and 300mg at bedtime, **Lamictal**- 100mg 1x per day. Resident B's file contains hospitalization records documenting that Resident A was hospitalized on 8/11/21 for psychiatric treatment and released back to this facility on 8/25/21. Resident B's file contains prescriptions issued on the date he was discharged from the hospital on 8/25/21 with the following changes: **Depakote-** 1000mg daily, **Clozapine-** 150mg in the morning, and 200mg in the evening, **Lamictal**- no longer prescribed. Resident B's medication log documents that he was given the pre-hospitalization dosages until a medication review was conducted on 8/30/21 and that Resident B's Clozapine ran out on 8/26/21.

Shanita Coleman, facility manager, stated on 10/18/21 that Resident B was admitted to the hospital on 8/11/21 because he had a psychotic breakdown. Ms. Coleman stated that Resident A had eloped from his work program and was experiencing hallucinations. Ms. Coleman stated that while Resident B was in the hospital, she noticed that there was about a week supply of Resident A's medications remaining, so she called Genesee Health System (GHS) using the number they have for requesting a refill of the medications. Ms. Coleman stated that no one responded, and no prescription was sent to the pharmacy to refill Resident B's medications. Ms. Coleman stated that Resident B was then returned to the facility on 8/25/21 with the new prescriptions for changes in Resident A's medications. Ms. Coleman stated that the staff are trained that a "DC" (discontinue order) is needed from a physician before a new prescription can be given but no "DC" was sent. Ms. Coleman stated that she called GHS again on 8/25/21 to request a refill of Resident B's medication (specifically Clozapine). Ms. Coleman stated

that the pharmacy will not fill a new prescription with psychiatric medications until a medication review is completed, so Ms. Coleman requested an “emergency” medication review on 8/25/21, but the medication review was not scheduled until 8/30/21. Ms. Coleman stated that Resident B’s last dosage of Clozapine was given on 8/26/21 and the new prescription was not filled until 8/30/21 so Resident B did not get this medication for three days (8/27/21, 8/28/21, and 8/29/21). Ms. Coleman stated that the new prescription was then sent to a pharmacy in another city and had to be resent back to the pharmacy used by this facility. Ms. Coleman stated that she feels that there was confusion with the staff because even though they did get the new prescriptions when Resident B was discharged from the hospital on 8/25/21, they did not receive a “DC” order for his current medications and that the pharmacy would not fill the new prescriptions without a medication review being completed.

Kim Nguyen-Forbes, recipient right officer, stated on 10/19/21 that she did investigate this incident. Ms. Nguyen-Forbes stated that she did substantiate a violation of Resident B’s rights. Ms. Nguyen-Forbes stated that Resident B was hospitalized for about two weeks for psychiatric treatment, and while in the hospital Resident B’s medication dosages were changed and new prescriptions were issued by the doctor at the hospital. Ms. Nguyen-Forbes stated that Ms. Coleman also reported to her that the staff are trained by the provider (Central State Community Services Inc.) that they cannot administer medications prescribed by a hospital physician without first getting a DC from the resident’s primary physician. Ms. Nguyen-Forbes stated that this is not a requirement of GHS and that Resident B’s prescriptions ordered on 8/25/21 should have been filled and the changes should have been made on 8/25/21. Ms. Nguyen-Forbes stated that a pharmacy does not require a medication review if the prescriptions are ordered by a physician and the prescriptions should have been sent to the pharmacy on 8/25/21. Ms. Nguyen-Forbes stated that she consulted with the primary prescriber of psychotropic medication for Resident B through GHS, and that she was informed that the facility staff should have followed *hospital orders* upon discharge until they followed-up with her, i.e., facility staff should have only administered medications to Resident B that were given in the discharge instructions and disregard any prescriptions beforehand, until they followed-up with her. Ms. Nguyen-Forbes stated that the prescriber also reported that Facility staff should have informed her or her office that Resident B was out of medication (Clozapine) and requested a refill, prior to his follow-up appointment, to avoid disruptions in his treatment as Clozapine is a medication that cannot be stopped and started abruptly, as it requires that it be introduced and weaned off at therapeutic levels to prevent risk of seizures. Clozapine should also be administered as prescribed to reduce lack of symptom control.

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:	The complainant reported that Resident B was in the hospital and discharged back to the facility on 8/25/21. The complainant reported that Resident B was issued new prescriptions while in the hospital and the prescriptions were given to staff at the facility when Resident B was discharged on 8/25/21. The new prescriptions issued on 8/25/21 were observed in Resident B's file and changed the dosage of Depakote and Clozapine. Resident B's medication log for August 2021 document that Resident B was still given the pre-hospitalization dosages until 8/30/21. The medication log also documents that Resident B was not administered Clozapine for three days due to the facility running out of the medication. Ms. Coleman stated that the staff have been trained that they are not to administer prescriptions issued by hospital physicians until they receive a DC order from the resident's primary physician if there is a medication change. Ms. Coleman stated that she called GHS while Resident A was in the hospital to have his medication refilled, but no prescription was sent. Ms. Coleman stated that the pharmacy will also not fill a prescription without a medication review being conducted at GHS, so she called and requested an "emergency" medication review on 8/25/21 because Resident B was going to run out of Clozapine, but the medication review was not scheduled until 8/30/21 so Resident B did miss three days of his Clozapine. Ms. Nguyen-Forbes stated that Resident B's prescription should have been filled on 8/25/21 and the new dosages administered on the same day. Ms. Nguyen-Forbes stated that there is no GHS policy that a hospital physician's orders require a DC

	order, and Resident B's primary medication prescriber has also stated that the discharge orders including the new prescriptions should have been implemented on 8/25/21. Ms. Nguyen-Forbes also stated that pharmacies do not require a medication review by GHS to fill new prescriptions. Ms. Nguyen-Forbes stated that the prescriber also reported that Facility staff should have informed her or her office that Resident B was out of medication (Clozapine) and requested a refill, prior to his follow-up appointment, to avoid disruptions in his treatment as Clozapine is a medication that cannot be stopped and started abruptly, as it requires that it be introduced and weaned off at therapeutic levels to prevent risk of seizures. Clozapine should also be administered as prescribed to reduce lack of symptom control. Based on the documentation reviewed and statements given, it is determined that there has been a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

An exit conference was conducted via email with Paula Ott, licensee designee, on 10/19/21. The findings in this report were reviewed.

IV. RECOMMENDATION

I recommend that the status of this license remain unchanged with the receipt of an acceptable corrective action plan.

10/19/2021

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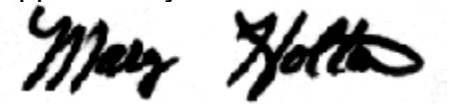
Kent W Gieselman Date
Licensing Consultant

Approved By:



10/20/2021

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Mary E Holton Date
Area Manager