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GOVERNOR

STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

ORLENE HAWKS DIRECTOR

October 19, 2021

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

> RE: License #: AS690382148 Investigation #: 2021A0009043 Pinehaven Red

Dear Mr. Harland:

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 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

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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 #:	2021A0009043
iiivootigatioii #:	2021/10000010
Complaint Receipt Date:	09/23/2021
Investigation Initiation Date:	09/23/2021
mivedigation mitiation bate.	00/20/2021
Report Due Date:	10/23/2021
Licensee Name:	Community Home & Health Convices I.I.C.
Licensee Name.	Community Home & Health Services LLC
Licensee Address:	657 Chestnut Ct
	Gaylord, MI 49735
Licensee Telephone #:	(989) 732-6374
Electrices Telephone #.	(666) 162 661 1
Administrator:	Jonathan Harland
Licensee Designee	Jonathan Harland
Licensee Designee:	Jonathan Hanand
Name of Facility:	Pinehaven Red
Facility Address.	118 McLouth Rd
Facility Address:	Gaylord, MI 49735
Facility Telephone #:	(989) 732-1614
Original Issuance Date:	05/31/2016
Original leddaned Bate.	00/01/2010
License Status:	REGULAR
Effective Date:	07/02/2021
Ellective Bate.	01702/2021
Expiration Date:	07/01/2023
Canacity	6
Capacity:	0
Program Type:	PHYSICALLY HANDICAPPED
	DEVELOPMENTALLY DISABLED
	MENTALLY ILL

II. ALLEGATION(S)

Violation Established?

A staff person stole narcotics from the home.	Yes
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III. METHODOLOGY

09/23/2021	Special Investigation Intake 2021A0009043
09/23/2021	Special Investigation Initiated – Telephone call received from licensee designee/administrator Mr. Jonathan Harland
09/24/2021	Contact – Telephone call made to administrator Ms. Kris Rambo, Community Home and Health Services
09/28/2021	Inspection Completed On-site Interview with administrator Ms. Kris Rambo Face to face with Resident A
10/18/2021	Contact – Telephone call made to former direct care worker Ms. Theresa Coger
10/19/2021	Exit conference with licensee designee/administrator Mr. Jonathan Harland

ALLEGATION: A staff person stole narcotics from the home.

INVESTIGATION: I received a telephone call from licensee designee/administrator Mr. Jonathan Harland on September 23, 2021. He said that a staff person at the Pinehaven Red facility likely stole some of Resident A's narcotic pills. This was first discovered the day before, when direct care workers Ms. Ashley Stiles and Ms. Theresa Coger were working. Ms. Coger was sleeping during her shift and Ms. Stiles could not wake her up. Ms. Stiles was reportedly concerned and knew that something was wrong with her coworker. She called administrator Ms. Kris Rambo and Mr. Harland was also contacted. Mr. Harland stated that he arrived on-site and Ms. Coger was still sleeping. He had to talk to her in a stern voice to get her to respond and wake up. She was described as being "out of it". Ms. Coger told him that she was just tired. Mr. Harland stated that he told her to go home and called in an administrator to fill in for her. Another administrator, Ms. Kris Rambo, then came on-site to examine the medical records. Ms. Rambo asked Mr. Harland to come back to the office/medication room and told him that 5 of Resident A's narcotic pills were missing. They use a system where each shift counts the residents' medications. The staff person who worked before Ms. Coger documented that the pills were all present. Ms. Coger was the staff person who had access to the

medication following that accurate count. Ms. Coger's behavior along with the narcotic medication going missing during her shift caused them to believe she stole and ingested some or all of the pills. He went on to say that he was there to meet Ms. Coger this morning as she came in to work. Mr. Harland confronted her on what they had found and she denied knowing anything about it. He told her that she was suspended pending an investigation into the matter. Mr. Harland said that he asked Ms. Rambo to contact law enforcement and report the situation to them. He stated that he did feel that they have procedures in place to try to catch this when it does happen. This includes the medication counts which, in this case, narrowed it down to Ms. Coger being the one who took the pills. I asked Mr. Harland about Resident A's condition given that he had possibly missed medication. Mr. Harland explained that the medication is given "as-needed" for pain and Resident A had not been exhibiting signs of being in pain.

I spoke with administrator Ms. Kris Rambo by phone on September 24, 2021. She stated that she had contacted law enforcement about the matter yesterday and an officer had come right over to Pinehaven Red. She provided him with the paperwork which led them to believe that Ms. Coger had taken the narcotics. The officer called Ms. Coger and she confessed to taking the pills. She said that she only took the 5 pills "as far as she knew". Ms. Coger admitted that she had used a coworker's password to document the 2nd worker supervising the medication administration. Ms. Rambo denied that Ms. Coger had administration rights in the computer system so must have somehow gained a coworker's password.

I made an unannounced site inspection at Pinehaven Red on September 28, 2021. I wore personal protection equipment to protect myself and others. Administrator Kris Rambo was on-site at the time of the visit. She explained what they knew so far about the stolen narcotics. Resident A came back from the hospital on September 16, 2021, with the as-needed narcotics prescribed to him. Direct care worker Ashley Stiles stated that Ms. Coger had asked her if she had any "Norco" available for purchase after that. Ms. Stiles said no, not being a drug user. According to the medication count sheets, 5 of Resident A's "as-needed" narcotic pills went missing between September 19 and September 23, 2021. The documents point to Ms. Coger being the one who stole the pills. The officer investigating the case used the documentation to leverage the confession from Ms. Coger. Ms. Coger's employment with Community Home and Health Services has been terminated.

I spoke with former direct care worker Theresa Coger by phone on October 18, 2021. She admitted that she stole one of Resident A's "Tylenol 3's". She stated, "They are trying to get me for five, but I only took one." Ms. Coger said that she really didn't try to hide it because Resident A's medication counts were "already off".

APPLICABLE RUL	E
R 400.14312	Resident medications.

	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	It was confirmed through this investigation that prescription medication was used by a person other than the resident for whom the medication was prescribed. On September 22, 2021, direct care worker Theresa Coger exhibited noticeable lethargy while at work when she was found sleeping on-duty. A coworker was unable to wake her. Documentation showed that 5 of Resident A's narcotic pills were unaccounted for and Ms. Coger later admitted to taking Resident A's prescription medication.
CONCLUSION:	VIOLATION ESTABLISHED

I conducted an exit conference with Mr. Jonathan Harland by phone on October 19, 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.

ada Polrage	10/19/2021
Adam Robarge	Date
Licensing Consultant	
Approved By:	
Jen Handles	
0 0	10/19/2021
Jerry Hendrick	Date
Area Manager	