GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 19, 2022

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

RE: License #:	AS560012112
Investigation #:	2022A0123015
	Mitchell House

Dear Ms. Ott:

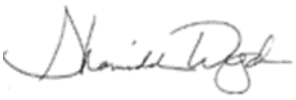
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS560012112
Investigation #:	2022A0123015
Complaint Receipt Date:	12/15/2021
Investigation Initiation Date:	12/15/2021
Report Due Date:	02/13/2022
Licensee Name:	Central State Community Services, Inc.
Licensee Address:	Suite 201 2603 W Wackerly Rd Midland, MI 48640
Licensee Telephone #:	(989) 631-6691
Administrator:	Brett Perhase
Licensee Designee:	Paula Ott
Name of Facility:	Mitchell House
Facility Address:	305 E St Andrews St Midland, MI 48640
Facility Telephone #:	(989) 631-4982
Original Issuance Date:	06/08/1983
License Status:	REGULAR
Effective Date:	10/25/2021
Expiration Date:	10/24/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Staff did not schedule a three-month follow-up appointment for Resident A and was not getting the required blood draws needed due to taking Clozaril. Resident A ran out of her Clozaril. Resident A missed three doses of medication between 12/10/2021 and 12/12/2021.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/15/2021	Special Investigation Intake 2022A0123015
12/15/2021	Special Investigation Initiated - Telephone I spoke with recipient rights investigator Phyllis Kchodl via phone.
12/21/2021	APS Referral An APS referral was completed.
12/22/2021	Inspection Completed On-site I conducted an un-announced on-site visit at the facility.
01/03/2022	Contact - Telephone call made I made a follow-up call to the facility and spoke with staff Alexis Christian.
01/03/2022	Contact - Document Received I received requested documentation via fax.
01/18/2022	Contact - Telephone call made I made a call to the facility. I interviewed staff Tyler Houghtaling.
01/18/2022	Contact - Telephone call made I spoke with Resident A's public guardian, Guardian 1 via phone.
01/19/2022	Contact- Telephone call made I left a message requesting a return call from licensee designee Paula Ott regarding an exit conference.
01/19/2022	Exit Conference I spoke with licensee designee Paula Ott via phone.

ALLEGATION: Staff did not schedule a three-month follow-up appointment for Resident A and was not getting the required blood draws needed due to taking Clozaril. Resident A ran out of her Clozaril. Resident A missed three doses of medication between 12/10/2021 and 12/12/2021.

INVESTIGATION: On 12/15/2021, I spoke with recipient rights investigator Phyllis Kchodl via phone. Ms. Kchodl stated that she does not know what happened, but that Resident A ran out of medication, including Clozaril. Resident A saw a nurse practitioner in March 2021, but Resident A was a no-show in June 2021. The facility made a call due to not enough medication and received a re-fill. In October 2021, there was a medication review and prescriptions were re-filled. There was no blood draw done in December due to Mitchell House having active COVID-19 cases in the home at the time. It took three days after the end of the quarantine to have the blood draw completed, and the facility stated that three doses had been missed. But, per the pharmacy, there were 13 missed does. Ms. Kchodl stated that it is unclear if maybe Resident A was hospitalized during anytime which could explain having extra doses. She stated that there were no incident reports to confirm any hospitalizations.

On 12/22/2021, I conducted an unannounced on-site visit at the facility. I made a face-to-face with Resident A. Resident A was standing in the dining room area of the home. She appeared clean and appropriately dressed. She stated that she takes medications three times per day. She denied knowing what types of medications she takes. She stated that staff administers her medication. She denied knowing what Clozaril is.

During this on-site I made a face-to-face with home manager Alexis Christian. Staff Christian stated that in late November 2021 or early December 2021 the mobile blood lab came out. Resident A had COVID-19 so the mobile lab could not come in. Resident A got over COVID-19, and there was a doctor's appointment on 12/09/2021 and had her blood labs completed the same day. Resident A received her Clozaril script, then had to wait for approval from Community Mental Health (CMH) to get the script filled. Staff Christian stated that they have never had an issue as far as waiting for CMH approval. Staff Christian stated that Resident A missed her Clozaril does on 12/10/2021, 12/11/2021, and 12/12/2021. She stated that Resident A received her prescription on 12/13/2021. She stated that there was a mix-up with the pharmacy who said there were 13 missed doses. Staff Christian stated that the pharmacy changed Resident A to a 28-day schedule, and before that it was a two-week schedule, and before this it was a weekly schedule. She denied that there were 13 missed doses at any point. She stated that Resident A did not have an increase in behaviors or anything because of the missed doses. Staff Christian stated that Resident A had a follow-up appointment on 06/18/2021 with Dr. Larry Beck through CMH, and that Resident A has follow-up appointments about every three months which have been phone calls due to COVID-19. Staff Christian stated that for 12/10/2021 through 12/12/2021 she did not work those three days and would have to see whether incident reports were made for the missed doses.

A copy of Resident A's medication administration records for December 2021 was obtained during this on-site. Staff initials are circled for Clozaril (*Clozapine 100 MG PO TAB Take 3 tablets by mouth at bedtime*) for 12/10/2021 through 12/12/2021. The explanation for the missed doses is only noted for 12/10/2021 (*out of med waiting on CMH*) and 12/12/2021 (*Out of med waiting on CMH*).

A copy of an incident report dated for 10/15/2021 was obtained during this on-site. The incident report states that Resident A had issues with her behavior and that staff had to verbally redirect her, after Resident A began screaming at the blood lab staff and staff Crystal Thorne after asking for a piece of candy that neither had. This occurred after Resident A had completed her blood draw appointment at the Orchard Building in Midland, MI.

On 01/03/2022, I received three incident reports dated for 12/10/2021, 12/11/2021, and 12/12/2021, where assistant home manager Tyler Houghtaling and staff Olivia Rodriguez documented that Resident A was "out of medication" on all three incident reports. The corrective measures for each incident report states, "*communicate better with CMH/pharmacy/blood lab to get meds/authorizations if needed."*

On 01/03/2022, I received via fax, a copy of Resident A's assessment plan. The assessment plan notes that "*staff will lock up & administer all medication."*

On 01/18/2022, I made a call to the facility. I interviewed assistant home manager Tyler Houghtaling. Staff Houghtaling stated that they were planning to get Resident A's blood drawn, but the home got COVID-19. He stated that this was explained to a Community Mental Health (CMH) nurse. The nurse said she would set up the blood draw appointment for Resident A. He stated that they waited for this, but there was no follow through from the nurse. He stated that they got Resident A's appointment set up, but then the pharmacy would not refill Resident A's prescription because their records showed that she had been out of medication for a while. He stated that this was not true, and that Resident A had either run out the day the pharmacy was called, or the day before. He stated that there was a new script written when the call was made to the pharmacy, but the pharmacy also said they needed approval from CMH. He stated that he thinks it took CMH a while to respond, and eventually sent their approval over. He stated that he did not observe any side effects from Resident A missing her Clorazil doses.

On 01/18/2022, I spoke with Resident A's public guardian, Guardian 1 via phone. Guardian 1 stated that they were made aware of the situation, and that the issue has been rectified. Guardian 1 denied having any further concerns.

On 10/27/2020, I concluded in Special Investigation Report #2020A0123044, that the facility violated rule R400.14312(2) due to Resident A running out of her Clozaril medication. Resident A's last dose was 09/17/2020, and she went without her medications from 09/18/2020 through 09/24/2020 until she was hospitalized on 09/25/2020. The corrective action plan dated 11/03/2020, and received on

11/06/2020, states that staff Alexis Christian received a performance correction on 11/03/2020, and there was an in-service completed with staff to discuss proper medication protocol, proper administration, five rights, and proper documentation and medication reordering. The corrective action plan is signed by licensee designee Paula Ott.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Staff Christian stated that in late November 2021 or early December 2021 the mobile blood lab came out. Resident A had COVID-19 so the mobile lab could not come in. Resident A had her blood labs completed on 12/09/2021. After receiving her script for Clozaril, staff had to wait for approval from CMH to get the script filled. As a result, Resident A missed three doses of Clozaril between 12/10/2021 and 12/12/2021. Staff Houghtaling also reported that the facility was awaiting CMH approval, and Resident A missed three doses. On 01/03/2022, I received three incident reports dated for 12/10/2021, 12/11/2021, and 12/12/2021, where assistant home manager Tyler Houghtaling and staff Olivia Rodriguez documented that Resident A was “out of medication” on all three incident reports. Guardian 1 reported being notified of the issue, and that it has been rectified. Guardian 1 denied having any further concerns. There is a preponderance of evidence to substantiate a rule violation due to Resident A missing three doses of her medication.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR#2020A0123044, dated October 27,2020**

ADDITIONAL FINDINGS:

INVESTIGATION: On 12/22/2021, I conducted an unannounced on-site visit at the facility. I requested a copy of Resident A’s *Health Care Appraisal*. I obtained a copy of an appraisal dated for 06/24/2020.

On 01/03/2022, I made a call to the facility and spoke with Staff Christian. I inquired about Resident A’s *Health Care Appraisal*. She stated that Resident A has a new

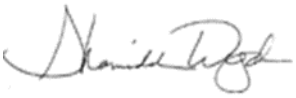
doctor, and her *Health Care Appraisal* did not get updated after the old physician dropped Resident A as a patient back during the summertime. She stated that it took about three months to get Resident A a new doctor. She stated that Resident A had her first appointment with her new physician on 10/14/2021, and the doctor's office has not faxed back a completed *Health Care Appraisal*.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	During an unannounced on-site visit I requested a copy of Resident A's Health Care Appraisal. The appraisal was dated 06/24/2020. On 01/03/2022, I inquired about an updated *Health Care Appraisal* and was informed by staff Alexis Christian that there was no updated *Health Care Appraisal* on file for Resident A. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 01/19/2022, I conducted an exit conference with licensee designee Paula Ott via phone. I informed her of the findings and conclusions.

IV. RECOMMENDATION

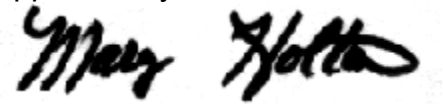
Contingent upon receipt of an acceptable corrective action plan, I recommend continuation of this AFC small group home license (capacity 6).



01/19/2022

Shamidah Wyden Date
Licensing Consultant

Approved By:



01/19/2022

Mary E Holton Date
Area Manager