GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 10, 2023

Daniel Phillips
Covenant Enabling Res of MI Inc.
862 Forest Park Road
Muskegon, MI 49441

RE: License #:	AS610089223
Investigation #:	2023A0356010
	Mary's House

Dear Mr. Phillips:

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 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS610089223
Investigation #:	2023A0356010
Complaint Receipt Date:	12/15/2022
Investigation Initiation Date:	12/16/2022
Report Due Date:	02/13/2023
Licensee Name:	Covenant Enabling Res of MI Inc.
Licensee Address:	862 Forest Park Road Muskegon, MI 49441
Licensee Telephone #:	(616) 550-1643
Administrator:	Daniel Phillips
Licensee Designee:	Daniel Phillips
Name of Facility:	Mary's House
Facility Address:	862 Forest Park Road Muskegon, MI 49441-4631
Facility Telephone #:	(231) 780-9144
Original Issuance Date:	05/31/2001
License Status:	REGULAR
Effective Date:	11/29/2021
Expiration Date:	11/28/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A's medications were not administered as prescribed.	Yes
Fire Drills are not properly documented.	Yes
Resident A missed medical appointments.	Yes
Additional Finding	Yes

III. METHODOLOGY

12/15/2022	Special Investigation Intake 2023A0356010
12/16/2022, 12/21/2022, 01/05/2023	Special Investigation Initiated - Telephone Referral Source-Anonymous
01/06/2023	Inspection Completed On-site
01/06/2023	Contact - Face to Face Tamia Taylor, Tara Tallquist, Residents A-E.
01/06/2023	Contact - Document Received Facility documents.
01/09/2023	Contact - Telephone call made Linda Wagner, ORR
01/17/2023	APS Referral-Centralized Intake
01/17/2023	Contact-Licensee Designee, Dan Phillips
01/18/2023	Contact - Telephone call made Linda Wagner, ORR.
01/26/2023	Contact - Face to Face Licensee Designee, Dan Phillips and home manager, Michelle (Yolandria) Tyson.
01/26/2023	Contact - Document Received facility documents.

02/09/2023	Contact-Telephone call made Trinity Health Physical Therapy, HealthWest nursing services, Family Medicine at Trinity Health, OIG-Mark Mandreky
01/30/2023	Contact-Documents Received Training documents
02/09/2023	Contact-Telephone call made Trinity Health, Rashanna Dotson, HW case manager, Jessica Sobers, HW nurse, Family Medicine at Trinity Health, Susan E.
01/26/2023 & 02/10/2023	Exit Conference-Dan Phillips, Licensee Designee.

ALLEGATION: Resident A's medications were not administered as prescribed.

INVESTIGATION: On 12/15/2022, I received a BCAL (Bureau of Children and Adult Licensing) Online Complaints. The complainant reported that the home manager is logging in information regarding distributing medication on 12/12/2022, but didn't dispense the medication to Resident A.

On 12/16/2022, I interviewed the anonymous referral source (RS) via telephone. The anonymous RS stated a medication error was discovered on Tuesday 12/13/2022 made by the home manager, Yolandria (Michelle) Tyson. The medication was a narcotic, Clonazepam, 1 mg, (take one tablet by mouth twice daily at 7:00a.m. and 8:00p.m.) that should have been passed to Resident A at 8:00p.m. on Monday evening 12/12/2022 but it was not passed. The RS stated on Tuesday 12/13/2022, when first shift staff got to work, staff was supposed to conduct a narcotic medication count with Ms. Tyson, but Ms. Tyson had something else to do and so the RS said first shift staff, Tamia Taylor did the count on her own and found the error in Resident A's medication, Clonazepam. The RS stated Ms. Tyson marked that she gave the medication, but she did not because Ms. Taylor discovered the pill in the packet and the pill was the last one in the pack that should have been passed. The RS reported Ms. Taylor confronted Ms. Tyson and Ms. Tyson claimed that she did pass the medication. The RS stated on Wednesday 12/14/2022 the pill that was not passed was observed in the package, but the seal was broken, and a piece of tape was over it.

On 01/06/2023, I conducted an unannounced inspection at the facility and interviewed Ms. Taylor. Ms. Taylor stated Resident A's Clonazepam 1 mg tab should have been passed on 12/12/2022 at 8:00p.m. but on 12/13/2023 the MAR (medication administration record) was signed as passed but the medication remained in the package and sealed. Ms. Taylor stated the following day, 12/14/2022, the seal on the packaging for the Clonazepam 1 mg tab was popped, a piece of tape was over it and the tablet was still in the package. Ms. Taylor stated

when staff administer medications out of the bubble pack, there is a number on the bubble pack that corresponds with the date that they take the medication from, so if a resident were given a pill on the 12th, the pill from the bubble pack with the number 12 next to it should be gone. Ms. Taylor stated she noted another possible medication error today and stated Resident A was out of the facility for the holidays from 12/20/2022 and returned on 01/04/2023. Ms. Taylor stated on the evening of the 4th, staff administered a PRN (as needed) Clonazepam to Resident A but instead of giving her the PRN, (as needed) Clonazepam, which instructs to take ½ tablet by mouth once daily as needed, it appears from the bubble pack that staff gave Resident A 1mg dose which is a full Clonazepam tablet rather than ½ tablet. Ms. Taylor stated there is a separate bubble pack for the PRN Clonazepam medications that has the medication already cut in half and packaged. Ms. Taylor stated the ½ pill for the date of the 4th is still in the PRN bubble pack leading her to think staff took a whole pill out of the other Clonazepam medication card that contained whole pills.

On 01/06/2023, I attempted to review the MAR for Resident A for December 2022. I observed Resident A's MAR for October 2022, November 2022, and January 2023 but the MAR for December 2022 was not available. Ms. Taylor stated the MAR for December 2022 may be in Ms. Tyson's office and Ms. Tyson was not at the facility at the time of this inspection.

On 01/06/2023, I reviewed the MAR for Resident A for January 2023. On 01/04/2023, staff BS (Brooke Stiver) signed that a PRN Clonazepam was administered, and this is the only documentation for the administration of this medication to date.

On 01/06/2023, I looked at the PRN bubble pack for Clonazepam ½ tablet and on the 4th, there is a half pill in the pack, but the 5th is punched out and so are 7 other pills punched out on different days on the PRN bubble pack card.

On 01/06/2023, I inspected the backs of the packaged medication cards and did not see tape over an opened medication however, on the PRN Clonazepam card under the number 2, the seal over the medication has a hole in it and the tablet is still in the package.

On 01/06/2023, I reviewed the narcotics/controlled substances record and there are three records, one for 8:00a.m. Clonazepam counts, one for 8:00p.m. Clonazepam counts and one for the PRN Clonazepam counts. Ms. Stiver documented on 01/04/2023 an 8:00p.m. Clonazepam administration while on the MAR Ms. Stiver documented a PRN as administered. In addition, DCW Tara Tallquist documented an 8:00p.m. Clonazepam medication administration for Resident A while she was LOA (on a leave of absence, out of the facility).

On 01/06/2023, I reviewed the staff notes dated 12/13/2022, Ms. Tyson documented on the notes, 'IR written for missing meds pass.'

On 01/06/2023, I interviewed Resident A at the facility. Resident A stated her head felt kind of funny on 01/04/2023 when she got back from her trip. Resident A stated she had been out of state and flew back on 01/04/2023 but had to spend an entire night in the airport. Resident A stated her medications were in a pill minder and sometimes she takes her medications on her own but other times her brother helps her but he was in Massachusetts, so she did it herself. Resident A stated she took her medications that evening at the airport and when she returned to the facility, she is not sure if she asked for a PRN Clonazepam but described being shaky, her hands were shaky and her "head was moving." Resident A stated she threw up a little bit and still "feels out of it" but attributes it to travel and sleeping in the airport. Resident A stated she "doesn't know what she gets" as far as medication but trusts staff to give her the medications she needs.

On 01/06/2023, I interviewed Residents B, C, D and E. The residents reported they get their medication. Staff administer their medication to them, and they trust staff to give the right medication at the right time.

On 01/06/2023, I interviewed DCW Tara Tallquist at the facility. Ms. Tallquist stated she administers resident medications as prescribed.

On 01/26/2023, I interviewed Licensee Designee, Dan Phillips and Ms. Tyson, home manager at the facility. Ms. Tyson stated staff conducted a medication count and noticed the medication error made on 12/12/2022. Ms. Tyson stated the medication error on 12/12/2022 was her fault. She missed the time to administer Resident A's medication and she wrote an IR (incident report), reported it to Jessica Grenell, Healthwest RN (registered nurse) and Rashanna Dotson, HealthWest case manager. Ms. Tyson stated Ms. Grenell instructed her to skip the med pass that she missed and administer the medication at the next time it is due. Ms. Tyson showed me a copy of an email received from Ms. Dotson and Ms. Grenell validating receipt of Ms. Tyson's verbal report of the medication error and documented that an IR was received.

Ms. Tyson stated staff Brooke Stiver signed the MAR on 01/04/2023 documenting that she administered a PRN Clonazepam tablet to Resident A on this date. Ms. Tyson stated the PRN card of medications is only given on an as needed basis and they do not get rid of the medication at the end of each month, if there is still medication left, that medication will be used into the next month and until it is used up. Ms. Tyson stated therefore, if staff punched out a PRN one month on the 5th and then the next month the 5th pill was gone, they would punch it out from elsewhere. That is where counting the narcotic medications comes in and the only time that count was off was when she (Ms. Tyson) made the medication error on 12/12/2022.

On 01/26/2023, I received the December 2022 MAR for Resident A. The MAR documented the initials MT on 12/12/2022 and the initials are circled. Ms. Tyson stated the circle indicate a medication error and that she made the error.

On 01/26/2023, I received and reviewed the IR dated 12/13/2023 and signed by Ms. Tyson. The date of the incident was 12/12/2023, 8:00p.m. The IR documented the following information, 'staff missed passing (Resident A's) Clonazepam 1mg PM tab. Staff called on call nurse to report incident. Resident missed dose due to out of range for med times. Also notified supports coordinator. Staff will continue buddy checks and staff will double check med cards and MARs while passing meds.'

On 01/26/2023, I conducted an exit conference with Licensee Designee, Dan Phillips at the facility. Mr. Phillips stated he understands the information, analysis, and conclusion of this applicable rule and that an acceptable corrective action plan will be submitted.

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 Resident A's 8:00p.m. dose of Clonazepam was not administered to Resident A on 12/12/2022. Ms. Taylor reported a medication error made on 12/12/2022 with Resident A's Clonazepam medication. Ms. Taylor reported another possible medication error on 01/04/2023 with Resident A's PRN Clonazepam. Ms. Tallquist reported she administers resident medications as prescribed. Ms. Tyson acknowledged she failed to administer Resident A's Clonazepam 1mg tab at 8:00p.m. on 12/12/2022. Ms. Tyson stated that is the only medication error made.

	The December 2022 MAR for Resident A has Ms. Tyson's initials circled which she stated indicates a medication error and that she made the error. The narcotics/controlled substance log documented an 8:00p.m. Clonazepam 1mg administration for Resident A on 01/04/2023 while on the MAR Ms. Stiver documented a PRN as administered. Residents B, C, D & E stated they trust staff to administer their medications as prescribed. Based on investigative findings it is determined that Ms. Stivers administered 1mg Clonazepam medication to Resident A at 8:00 p.m. on 01/04/2023 rather than a PRN and on 12/12/2022, Ms. Tyson did not administer Resident A's Clonazepam 1mg tablet in error. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Fire Drills are not properly documented.

INVESTIGATION: On 12/15/2022, I received a BCAL (Bureau of Children and Adult Licensing) Online Complaints. The complainant reported fire drill documents are being forged to indicate staff are conducting fire drills when they are not being done. The complainant reported that a fire drill was done by a specific staff member who has not worked in the facility and has never taken part in any drills.

On 01/05/2023, On 12/16/2022, I interviewed the anonymous referral source via telephone. The anonymous RS stated on 11/07/2022 a fire drill was documented as run by a staff member who was not working on that date. The complainant reported that dates on the fire drill records are blank and not always filled in properly.

On 01/06/2023, I interviewed Residents A, B, C, D and E individually at the facility. The residents reported that they all participate in fire drills and all residents reported they exit the facility and gather as a group outside by the garages. The residents reported the drills are "surprise" drills and they are conducted different times of the day and night.

On 01/06/2023, I interviewed Ms. Taylor at the facility. Ms. Taylor stated drills are run by staff however she did notice some drills were not documented properly One was undated, and another was run when the staff documented was not on the schedule. Ms. Taylor stated the drills are not documented by staff but documented by Ms. Tyson.

On 01/06/2023, I reviewed the fire drills for 05/2022-01/2023. The logs are completed except for the date on the December drill is missing and documented on the 11/7/2022 drill the staff present is documented as Tara (Tallquist) and on the staff schedule for the date of 11/7/2022 staff documented as working at that time is Tannisha Williams (former staff).

On 01/06/2023, I interviewed Ms. Tallquist at the facility. Ms. Tallquist stated she runs fire drills but is not certain how to document them, nor does she know where the fire drill logs are kept in the facility, so she leaves the information for Ms. Tyson to fill out the fire drill log. Ms. Tallquist confirmed she ran a drill on 01/02/2023 at 6:40a.m. and left the information for Ms. Tyson for the log.

On 01/26/2023, I interviewed Mr. Phillips and Ms. Tyson at the facility. Ms. Tyson stated fire drills are conducted every month at varying times meeting the rule for daytime, evening and sleeping drills. Ms. Tyson stated she documents the drills when she is present during the drill, but staff fill out the fire drill logs if she is not in the facility. Ms. Tyson provided copies of the fire drills which are the same as the drills I reviewed at the facility on 01/06/2023. Ms. Tyson added, when Ms. Tallquist's name was on the drill, she worked on that date. Ms. Tyson stated Ms. Williams was scheduled to work but there was a change in staff that day and it was not changed on the work schedule. Ms. Tyson stated during that time, staff changed shifts often to meet the staffing needs of the facility. Ms. Tyson stated the drills are run and documented each time they take place.

On 02/10/2023, I conducted an exit conference with Licensee Designee, Dan Phillips at the facility. Mr. Phillips stated he understands the information, analysis, and conclusion of this applicable rule and that an acceptable corrective action plan will be submitted.

APPLICABLE RULE	
R 400.14318	**Emergency preparedness; evacuation plan; emergency transportation.**
	(5) A licensee shall practice emergency and evacuation procedures during daytime, evening, and sleeping hours at least once per quarter. A record of the practices shall be maintained and be available for department review.
ANALYSIS:	The complainant reported fire drill documents are being forged to indicate staff are conducting fire drills when they are not being done. The anonymous RS stated fire drill records are blank and not always filled in properly.

	Residents A, B, C, D and E reported they practice fire drills regularly. Ms. Taylor stated the drills are not documented properly. A review of the fire logs showed mostly the fire logs are completed except for one missing the date the drill was conducted and possibly one with a wrong staff member documented. Ms. Tallquist stated she runs fire drills but is not certain how to document them and leaves the information for Ms. Tyson to complete. Ms. Tyson stated fire drills are practiced according to requirements and documented by staff or by her once the drill is complete. Based on investigative findings, fire drills at the facility are being practiced but the documentation of the fire drills is missing a date. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A missed medical appointments.

INVESTIGATION: On 12/15/2022, I received a BCAL (Bureau of Children and Adult Licensing) Online Complaints. The complainant reported Resident A was discharged from a medical provider for four no calls, no show appointment, but the staff was never notified that the resident had any appointments.

On 12/16/2022, I interviewed the anonymous referral source (RS) via telephone. The RS stated Trinity Health called the facility and reported that Resident A had missed too many appointments, so they had to discontinue her from their services. The RS stated Ms. Tyson schedules and takes residents to all doctor's appointments, for those residents who need staff to do so. The RS stated it was Ms. Tyson's responsibility to get Resident A to all her doctors appointments and there was nothing on the calendar, in the appointment book or in notes to indicate Resident A had any appointments. The RS thought the appointments were for physical therapy (PT).

On 01/06/2023, I conducted an unannounced inspection at the facility and interviewed Ms. Taylor and Ms. Tallquist. Ms. Taylor and Ms. Tallquist stated Ms. Tyson takes Resident A to her doctors appointments. Ms. Tallquist stated she saw a

note that Resident A had missed 4 PT appointments in a row and Resident A stated she lost the paper, so no one knew she even had the appointments.

On 01/06/2023, I interviewed Resident A at the facility. Resident A stated Ms. Tyson takes her to appointments and that she makes it to her appointments. Resident A acknowledged she missed Trinity health physical therapy appointments and stated, “but no one told me I had them.” Resident A stated Trinity Health set the appointments up for her and that she “didn’t know about them, I don’t know if Michelle (Tyson) did?” Resident A stated Ms. Tyson is a “very busy woman, she has other cases, and she can’t just drop everything.” Resident A stated she “doesn’t know who knew” about the appointments she missed other than Ms. Tyson.

On 01/06/2023, I interviewed Residents B, C, D and E at the facility. Resident B stated Ms. Tyson and a relative takes her to appointments and she makes it to all appointments. Resident C stated staff takes her to all appointments, possibly it is Ms. Tyson that takes her and that she makes it to all appointments. Resident D & E stated a relative takes them to their appointments and they make it to all appointments.

On 01/26/2023, I interviewed Mr. Phillips and Ms. Tyson at the facility. Ms. Tyson stated she takes Resident A to her appointments but for some reason, the physical therapy appointment reminders only went to Resident A’s cell phone and not to the facility. Ms. Tyson stated Resident A is her own guardian and put her own cell phone number on the paperwork. Ms. Tyson stated Resident A goes to Trinity Health for physical therapy, primary care, and cardiology but the only appointments Resident A missed were the physical therapy appointments. Ms. Tyson stated Resident A has an appointment on 03/01/2023 with her primary care physician and they will re-prescribe PT at that time and Ms. Tyson will make sure Resident A gets to the appointments.

On 02/09/2023, I interviewed Jessica Sobers, Health West RN (registered nurse) via telephone. Mr. Sobers stated Resident A makes all her mental health medical appointments at HealthWest.

On 02/9/2023, Interviewed Susan E. at Family Medicine at Trinity Health. Ms. E. stated Resident A sees her primary care doctor every 6 months and there are no issues with missed appointments.

On 02/10/2023, I interviewed Rashanna Dotson, Health West case manager for Resident A. Ms. Dotson stated she was not aware that Resident A missed PT appointments through Trinity Health.

On 02/10/2023. I received and reviewed Resident A’s Resident Care Agreement signed by Ms. Tyson that documents the basic fees include transportation services, ‘doctor’s appointments.’

On 02/10/2023, I conducted an exit conference with Licensee Designee, Dan Phillips at the facility. Mr. Phillips stated he understands the information, analysis, and conclusion of this applicable rule and that an acceptable corrective action plan will be submitted.

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:	Based on investigative findings, there is a preponderance of evidence to show that special medical procedures were not followed as prescribed by Resident A's licensed physician when Resident A missed 4 physical therapy appointments and therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION: On 01/06/2023, I interviewed Resident's A, B, C, D & E individually at the facility. Resident's C and D both stated staff always administer their medications but do not always watch them take their medications.

On 01/06/2023, I interviewed Ms. Tallquist at the facility. She stated she administers resident medications by placing them in cups with the residents initials on the cups and hands the medications to the residents. Ms. Tallquist stated she watches Resident's E & F take their medications, but she allows Resident's A, B, C & D to take their medications to their rooms if they choose to do so. Ms. Tallquist stated she gathers their medication cups when they are done taking their medications. Ms. Tallquist stated she does not always watch those residents take their medications.

On 01/26/2023, I interviewed Mr. Phillips and Ms. Tyson at the facility. Mr. Phillips and Ms. Tyson stated Ms. Tallquist has been trained on how to administer resident medications and should not allow residents to take medications to their room and administer them without supervision. Mr. Phillips and Ms. Tyson stated they will discuss with staff and retrain.

On 01/30/2023, I received and reviewed Ms. Tallquist medication training update dated 01/28/2023. Ms. Tyson stated Ms. Tallquist will begin in person medication training on 02/07/2023.

On 01/26/2023, I conducted an exit conference with Licensee Designee, Dan Phillips at the facility. Mr. Phillips stated he understands the information, analysis, and conclusion of this applicable rule and that an acceptable corrective action plan will be submitted.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	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:	Resident C and D stated staff do not always watch them take their medications. Ms. Tallquist stated she does not always watch residents take their medications and allows certain residents to take their medications to their rooms to take on their own. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

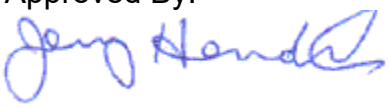
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

02/10/2023

Elizabeth Elliott Date
Licensing Consultant

Approved By:



02/10/2023

_____

Jerry Hendrick Date
Area Manager