GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 21, 2023

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

RE: License #: AS250010982
Investigation #: 2023A0569023
Warner House

Dear Ms. Barnes:

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) 643-7960.

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 #:	AS250010982
Investigation #:	2023A0569023
Complaint Receipt Date:	02/03/2023
Investigation Initiation Date:	02/06/2023
Report Due Date:	04/04/2023
Licensee Name:	Central State Community Services, Inc.
Licensee Address:	Suite 201 2603 W Wackerly Rd Midland, MI 48640
Licensee Telephone #:	(989) 631-6691
Administrator:	Sharon Butler
Licensee Designee:	Paula Barnes
Name of Facility:	Warner House
Facility Address:	2473 Warner Rd Flushing, MI 48433
Facility Telephone #:	(810) 733-2780
Original Issuance Date:	09/02/1992
License Status:	REGULAR
Effective Date:	09/30/2021
Expiration Date:	09/29/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff left medications in unmarked cups on the kitchen table for more than 15 minutes on 2/6/23.	Yes

III. METHODOLOGY

02/03/2023	Special Investigation Intake 2023A0569023
02/06/2023	Special Investigation Initiated - Letter email from Kim Nguyen-Forbes, RRO.
03/15/2023	Inspection Completed On-site
03/15/2023	Contact - Telephone call made. Attempted contact with Sylvia Golson, GHS case manager.
03/15/2023	Contact - Telephone call made. Attempted contact with Chanice Smith. No answer.
03/16/2023	Contact - Telephone call received. Contact with Sylvia Golson, case manager.
03/16/2023	Inspection Completed-BCAL Sub. Compliance
03/16/2023	Exit Conference Exit conference with Jamilla Banister, program manager in Paula Barnes' absence.
03/16/2023	APS referral. Referal made to APS.

ALLEGATION:

Staff left medications in unmarked cups on the kitchen table for more than 15 minutes on 2/6/23.

INVESTIGATION:

This complaint was received via the on-line complaint portal. The complainant reported that staff left the morning dose of the residents' medications in unmarked cups on the kitchen table for more than 15 minutes on 2/6/23. The complainant did not report any additional information.

An unannounced inspection of this facility was conducted on 3/15/23. The residents of this facility are not able of giving a reliable statement due to their diagnoses. All the residents were observed to be appropriately dressed and groomed with no visible injuries. The residents' needs were observed to be appropriately addressed. The medications were observed to be locked in a medication closet with a lock on the door handle. All the resident medications were observed to be sealed in labeled bubble packs with the pharmacy instructions. The facility staff schedule documents that Alana Moton and Chanice Smith were that staff assigned to work the first shift on 2/6/23.

Alana Moton, staff person, stated on 3/15/23 that she did work the first shift on 2/6/23. Ms. Moton stated that she had not completed her medication administration training at that time, so Ms. Smith was the staff who was administering the medication. Ms. Moton stated that she was in the kitchen, making breakfast for the residents on 2/6/23 when Sylvia Golson, GHS case manager, entered the kitchen to ask Ms. Moton why the resident medications were in unmarked cups and placed on the kitchen table. Ms. Moton stated that she then looked in the dining room, and each residents' place setting had an unmarked cup with their medication in the cup placed at the seat where each resident sits for meals. Ms. Moton stated that she was not sure how long the medications were on the table but guessed that the medications had been in the cups and on the table for 10-15 minutes. Ms. Moton stated that she then gathered the cups and placed them in the medication closet and locked the door. Ms. Moton stated that Ms. Smith then got the cups back out to give the residents' their medications. Ms. Moton stated that Ms. Smith's actions are not in compliance with the medication administration policy of this facility. Ms. Moton stated that the staff person who is administering the medication will call each resident, one at a time, to the medication closet, "pop" the medications from the bubble pack, and give the medication to the resident.

Sharon Butler, facility administrator, stated on 3/15/23, that Ms. Smith was terminated from employment following this incident. Ms. Butler stated that Ms. Smith did not follow the proper procedure while administering the resident medications on 2/6/23. Ms. Butler stated that staff are trained to individually administer each residents' medications directly from the pharmacy supplied and labeled container.

Sylvia Golson, GHS case manager, stated on 3/16/23 that she is the case manager for all the residents in this facility. Ms. Golson stated that she arrived at this facility during the morning of 2/6/23 to see the residents. Ms. Golson stated that when she walked into the facility, she observed cups at each of the residents' seats at the table with their morning doses of medication in the unmarked cups. Ms. Golson stated that she did not know how long the cups had been sitting unattended on the table. Ms. Golson stated that she then informed Ms. Moton that the medications could not be left on the table, so Ms. Moton then placed the cups into the medication closet.

An attempted contact with Ms. Smith was made via telephone. There was no answer or voicemail feature for the number used for the attempted contact.

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 all the resident medications were left in unmarked cups on the kitchen table on 2/6/23. Ms. Moton and Ms. Golson both stated that Ms. Smith had placed the resident medications in unmarked cups and left the cups unattended on the kitchen table on 2/6/23. Based on the statements given, it is determined that there has been a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

An exit conference was conducted on 3/16/23 with Jamila Banister, program manager, on 3/16/23 due to Paula Barnes, licensee designee, being on an extended absence. The findings in this report were reviewed.

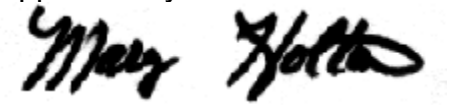
IV. RECOMMENDATION

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

3/16/23

Kent W Gieselman Date
Licensing Consultant

Approved By:



3/21/23

Mary E. Holton Date
Area Manager