GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 20, 2023

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

RE: License #: AS610089223
Investigation #: 2023A0350017
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 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 (616) 356-0100.

Sincerely,

Ian Tschirhart, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 644-9526

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS610089223
Investigation #:	2023A0350017
Complaint Receipt Date:	03/24/2023
Investigation Initiation Date:	03/24/2023
Report Due Date:	04/23/2023
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 was allowed to have over-the-counter medications in her room because she was her own.	Yes
There are insufficient staff to adequately care for the residents.	No
The residents' Bridge Cards are being used to purchase food for a different Adult Foster Care Home.	No
Two of Resident C's Xanax tablets were not accounted for.	Yes

III. METHODOLOGY

03/24/2023	Special Investigation Intake 2023A0350017
03/24/2023	Special Investigation Initiated - Telephone Allegations discussed with Tamia Taylor, Health Care Provider
03/28/2023	Contact - Face to Face I spoke with Tamia Taylor, DCW, and Resident B.
03/28/2023	Contact - Telephone call made I spoke with Rashanna Dotson, CMH Case Manager, and Caitlyn Keglovitz, Case Manager Supervisor.
03/29/2023	Contact - Telephone call made I spoke with Tara Tallquits, DCW.
03/29/2023	Contact - Telephone call received I spoke with Dan Phillips, Licensee Designee.
03/29/2023	Contact - Telephone call made I spoke with Jacki Stoltzfus, Home Manager of Joseph's House.
04/03/2023	Contact - Telephone call made I left a message for Rashanna Dotson, reminding her to send me the Assessment Plans and medication audit report.
04/04/2023	Contact - Telephone call received

	Ms. Dotson informed me that she sent an email with the Assessment Plans and that the nurses haven't done the medication audit yet.
04/04/2023	Contact – Document received I received an email from Ms. Dotson
04/10/2023	Contact – Document sent I sent an email to Ms. Dotson, reminding her to have the medication audit sent to me
04/10/2023	Contact – Document received I received an email from Ms. Dotson
04/14/2023	Contact - Telephone call received I received a call from Ms. Keglovitz saying she will email me the medication audit report
04/17/2023	Contact – Document sent I sent an email to Ms. Dodson
04/17/2023	Contact – Document received I received an email response from Ms. Dodson
04/20/2023	Exit conference – Held with Daniel Phillips, Licensee Designee

ALLEGATION: Resident A was allowed to have over-the-counter medications in her room because she was her own guardian.

INVESTIGATION: On 03/24/2023, Elizabeth Elliott, Adult Forster Care Licensing Consultant, spoke with Tamia Taylor, Direct Care Worker (DCW). Ms. Taylor informed Ms. Elliott of the allegations.

On 03/28/2023, this Special Investigation was reassigned to me, Ian Tschirhart.

On 03/28/2023, I spoke with Ms. Taylor at this home and asked her if Ms. Tallquits had purchased any over-the-counter (OTC) medications recently and she said she did. Ms. Taylor stated that Ms. Tallquits purchased some OTCs for Resident A, and gave her the bottles full of OTC's because Resident A was her own guardian. Ms. Taylor also told me that the other OTCs were for Resident B and Resident C and that those medications were kept locked up because both of these residents have legal guardians. I observed the medications out in the open in Resident A's room, which were Melatonin, Aspirin, and Vitamin B12. I asked Ms. Taylor to show me the other residents' OTC and I observed that they were kept locked up in the office. Ms.

Taylor informed me that the previous Home Manager quit a couple of weeks ago and that there currently isnt a Home Manager. She said that Dan Phillips, Assistant Administrator, is the acting Home Manager until a new one is assigned.

On 03/29/2023, I called and spoke with Ms. Tallquits, and she confirmed that she had purchased some decongestant from the dollar store for Resident B because her nose was stuffed up and she was coughing, etc. Ms. Tallquits said that there was no prescription for this and didn't know one was required for OTCs.

On 03/29/2023, I received a call from Dan Phillips, Licensee Designee, and went over the allegations with him. He said he was aware that Ms. Tallquits purchased Vitamin D for Resident A and let her keep it in her room. Mr. Phillips said that he thought if a resident was their own guardian they could keep OTCs in their rooms. However, he said he obtained the Vitamin D from Resident A and it is now kept locked up in the medication room. I informed Mr. Phillips that whether a resident has a guardian or not, all medications, including OTCs, need to be kept locked up. He said that he would make sure this happens from now on.

On 04/20/2023, I called and held an exit conference with Dan Phillips, Licensee Designee. I informed Mr. Phillips that I was citing a violation of this rule. He thanked me for informing him and had no further comment.

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:	Staff members Tamia Taylor and Tara Tallquits, and temporary Home Manager/Licensee Designee, Dan Phillips, were under the impression that residents who did not have guardians were allowed to have over-the-counter medications in their rooms. I observed Melatonin, Aspirin, and Vitamin B12 left out in the open in Resident A's room. My findings support that this rule had been violated.

CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: There are insufficient staff to adequately care for the residents.

INVESTIGATION: On 03/28/2023, I made an onsite inspection. I met and spoke with Ms. Taylor, going over each of the allegations. Ms. Taylor explained that there are currently only two staff members assigned to this house, herself and Tara Tallquits, but the company has been using staff members from their other homes. Ms. Taylor reported that there was always at least one DCW on each shift. I asked her if any of the six residents require two-person assistance for any reason and she said no. I asked to review each of the resident's Assessment Plans, and she brought them out. I observed that none of the residents required two-person assistance for any reason. Ms. Taylor told me that only Resident A uses a wheelchair, and said that Resident A does not require any assistance getting in and out of the wheelchair or to use the toilet or for any other reason.

On 03/28/2023, I called and spoke with Rashanna Dotson, Case Manager, who requested the call be on speakerphone so that her supervisor, Caitlyn Keglovitz, could be a part of the conversation. I agreed and asked them if it was in writing that any of the residents require two-staff assistance, and Ms. Keglovitz said there wasn't.

On 03/29/2023, I received a call from Mr. Phillips, and I told him that I spoke with Caitlyn Keglovitz, Case Manager Supervisor at Health West, the Community Mental Health agency that provides services to residents at this home. I informed Mr. Phillips that Ms. Keglovitz reported to me that some of the residents' Assessment Plans were dated October 2022, and that some Assessment Plans were not signed or dated.

On 04/03/2023, I called and left a message for Ms. Dotson, inquiring about the Assessment Plans.

On 04/04/2023, I received a call from Ms. Dotson, who told me she just sent me an email with the Assessment Plans attached.

On 04/04/2023, I received an email from Ms. Dotson with the Assessment Plans attached. I reviewed the residents' Assessment Plans and observed that none of them showed that a resident requires two-person assistance for any reason.

On 04/20/2023, I called and held an exit conference with Dan Phillips, Licensee Designee. I informed Mr. Phillips that I was not citing a violation of this rule. He thanked me for informing him and had no further comment.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	There is at least one staff member on duty every shift at this home. In reviewing the residents' Assessment Plans and speaking with Rashanna Dotson, CMH Case Manager, and her supervisor, Caitlyn Keglovitz, I discovered that no resident at this home requires two-person assistance for any reason. My findings do not support that this rule had been violated.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: The residents' Bridge Cards are being used to purchase food for a different Adult Foster Care Home.

INVESTIGATION: On 03/28/2023, I spoke with Ms. Taylor at this home and asked her if any of the residents' Bridge Cards were being used to buy food at Joseph's House, the AFC home next door that this company also owns and operates. She stated that she believed so because she saw Resident B's Bridge Card on the desk in the office that had a sticky note on it that stated something like, "Sorry, I forgot I had this card in my wallet." It was signed by Jacki Stoltzfus, the Home Manager of Joseph's House. I asked to see the card and note, and Ms. Taylor showed it to me and I saw the note as well. It was just as Ms. Taylor said.

On 03/29/2023, I called and spoke with Tara Tallquits, DCW. I asked Ms. Tallquits if she knew whether Resident B's Bridge Card was being used to purchase food for Joseph's House, and she said she wasn't sure. She did say, however, that she found Resident B's Bridge Card on the desk at Mary's House with a sticky note on it from Ms. Stoltzfus that said, "Sorry, I forgot I had this card in my purse." Ms. Tallquits added that although Ms. Stoltzfus is the Home Manager of Joseph's House, she sometimes fills-in at Mary's House.

On 03/29/2023, I called and spoke with Jacki Stoltzfus, Home Manager of Joseph's House, which is next to Mary' House. I asked Ms. Stoltzfus if any of the Mary House residents' Bridge Cards were being used to purchase food for Joseph's House, and she replied, "Absolutely not." She then said that she did leave Resident B's Bridge Card with a note attached to in on the desk in the office at Mary's House. Ms.

Stoltzfus informed me that just before the former Home Manager of Mary's House left, she told Ms. Stoltzfus that she forgot she had Resident B's Bridge Card in her purse and gave the card to her. Then Ms. Stoltzfus attached the note explaining this to the card and left on the desk.

On 03/29/2023, I received a call from Mr. Phillips, and I informed him of the allegation that Resident B's Bridge Card was being used to purchase food for another home. I told him, however, that I leaned that the former Home Manager had this resident's Bridge Card in her purse and forgot about it, and that when she found it she gave it to Ms. Stoltzfus, who put a sticky note on it and left it on the desk at Mary's House. Mr. Phillips stated that each resident in both homes (Mary's House and Joseph's House) has his or her own Bridge Card, implying there would be no need to use someone's Bridge Card to be used for another house.

On 04/20/2023, I called and held an exit conference with Dan Phillips, Licensee Designee. I informed Mr. Phillips that I was not citing a violation of this rule. He thanked me for informing him and had no further comment.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(2) The care of any resident funds and valuables that have been accepted by a licensee for safekeeping shall be treated by the licensee as a trust obligation.
ANALYSIS:	Each resident of both Mary's House and Joseph's House has their own Bridge Card. Ms. Stoltzfus, the Home Manager of Joseph's House who also fills in at Mary's House stated resident Bridge cards are not used for a home other than the one they reside in. Dan Phillips, Licensee Designee, also stated that every resident from both houses has their own Bridge Card and no one's card is used to purchase food for the other AFC home. My findings do not support that this rule had been violated.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Two of Resident C's Xanax tablets were not accounted for.

INVESTIGATION: On 03/28/2023, I spoke with Ms. Taylor at this home and asked her if two of Resident C's Xanax tablets were missing and she said yes. Ms. Taylor explained to me that she observed the Narcotic Tracking Log showed that the last

time a Xanax was given to Resident C was on 03/08/2023, leaving six pills left. However, she noticed that there were only four pills in the package. Ms. Taylor stated that there was no mention of a staff member giving Resident C a Xanax after this date in the staff's Progress Notes. I also observed the Medication Administration Records (MARs) and it showed that the last time Resident C was given a Xanax was on 03/08/2023. I asked Ms. Taylor if I could speak with Resident C and she took me to her. I introduced myself to Resident C and asked her when the last time she asked for a Xanax and she reported, "A couple of days ago," and that it was Ms. Tallquits who gave it to her. She did not remember when she had one before that.

On 03/29/2023, I called and spoke with Tara Tallquits, DCW. I asked Ms. Tallquits if she was aware that the count of Resident C's Xanax pills was short, and she said, "Oh, I forgot to write it in." Ms. Tallquits stated that a few days ago, Resident C asked her for a Xanax in the middle of the night, and she gave it to her, but she

forgot to document it. I informed her that there were two pills unaccounted for, and she said she didn't about the other one, just the one she forgot to log.

On 03/29/2023, I received a call from Mr. Phillips, and I informed him that I observed Resident C's Xanax pill count was off by two, that there were two less pills than there should be. I also told him that Ms. Tallquits told me she forgot to log that she gave one to Resident C; therefore, there was actually only one unaccounted for. Mr. Phillips told me that he passed a Xanax the evening before (03/28) and also noted the count was off by two.

On 03/28/2023, I called and spoke with Rashanna Dotson, Case Manager, who requested the call be on speakerphone so that her supervisor, Caitlyn Keglovitz, could be a part of the conversation. I agreed, and Ms. Keglovitz informed me that there were previous concerns about medication errors at this home. She informed me that some nurses were going to Mary's House tomorrow, 03/29, to do a Medication Audit. I requested a copy of their written findings when completed and Ms. Keglovitz said she would send it to me.

On 04/20/2023, I called and held an exit conference with Dan Phillips, Licensee Designee. I informed Mr. Phillips that I was citing a violation of this rule. He clarified that there was only one Xanax, not two, that was unaccounted for, I confirmed that that was correct. He thanked me for informing him and had no further comment.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: (b) Complete an individual medication log that contains all of the following information:

	(i) The medication. **(ii) The dosage.**
ANALYSIS:	At first, two of Resident B's Xanax pills were unaccounted for. Then Tara Tallquits, DCW, stated that she passed Resident B a Xanax but forgot to log in the Medication Administration Record or the Controlled Substance Log. This left one Xanax pill unaccounted for as the Controlled Substance Log showed there were six pills left, but there were only four in the package; however, as stated, one was later accounted for. My findings support that this rule had been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

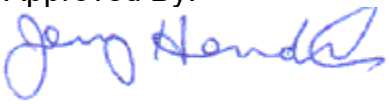
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend that the status of this home's license remain unchanged, and that this special investigation be closed.

April 20, 2023

Ian Tschirhart — Date
Licensing Consultant

Approved By:



April 20, 2023

Jerry Hendrick — Date
Area Manager