GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 13, 2023

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

RE: License #: AS630407345
Investigation #: 2023A0991032
Waterview Home

Dear Paula 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 (248) 975-5053.

Sincerely,

Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630407345
Investigation #:	2023A0991032
Complaint Receipt Date:	08/09/2023
Investigation Initiation Date:	08/10/2023
Report Due Date:	10/08/2023
Licensee Name:	Central State Community Services, Inc.
Licensee Address:	2603 W Wackerly Rd - Suite 201 Midland, MI 48640
Licensee Telephone #:	(989) 631-6691
Licensee Designee:	Paula Barnes
Name of Facility:	Waterview Home
Facility Address:	121 Waterview Lake Orion, MI 48362
Facility Telephone #:	(248) 690-9280
Original Issuance Date:	05/18/2021
License Status:	REGULAR
Effective Date:	11/18/2021
Expiration Date:	11/17/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 08/03/23, Resident A attempted to do his own dishes, but staff, Danielle Williams, told him that he could not. This caused Resident A to become upset and the police were called. Ms. Williams failed to comply with Resident A's treatment plan, by not allowing him to wash his own dishes.	No
Staff failed to schedule a psychiatric appointment for Resident B after it was recommended on 05/12/23. Staff were passing Melatonin to Resident B, but there was no prescription in the home and this medication is not listed on his medication administration record.	Yes

III. METHODOLOGY

08/09/2023	Special Investigation Intake 2023A0991032
08/10/2023	Special Investigation Initiated - Face to Face Unannounced onsite inspection
08/10/2023	Referral - Recipient Rights Received from Office of Recipient Rights (ORR)
08/10/2023	Contact - Document Sent Email to Office of Recipient Rights (ORR) team lead, Alanna Honkanen
08/10/2023	Contact - Telephone call received From program director
08/10/2023	Inspection Completed On-site Unannounced onsite inspection
08/24/2023	Inspection Completed On-site Unannounced onsite inspection- no answer at home
08/24/2023	Contact - Telephone call made To home manager, Danielle Williams

08/25/2023	Contact - Document Received Received additional allegations
08/25/2023	APS Referral Referred to Adult Protective Services (APS) Centralized Intake
08/28/2023	Inspection Completed On-site Unannounced onsite inspection- interviewed medication coordinator and Resident A
08/28/2023	Contact - Document Received Medication administration record, prescription, medical documents
08/29/2023	Contact - Document Received Email from ORR worker, Rishon Kimble
10/06/2023	Exit Conference Left message for licensee designee, Paula Barnes

ALLEGATION:

On 08/03/23, Resident A attempted to do his own dishes, but staff, Danielle Williams, told him that he could not. This caused Resident A to become upset and the police were called. Ms. Williams failed to comply with Resident A's treatment plan, by not allowing him to wash his own dishes.

INVESTIGATION:

On 08/09/23, I received a complaint alleging that on 08/03/23, Resident A attempted to do his own dishes, but staff, Danielle Williams, told him that he could not. This caused Resident A to become upset and the police were called. Ms. Williams failed to comply with Resident A's treatment plan, by not allowing him to wash his own dishes.

I initiated my investigation on 08/10/23, by conducting an unannounced onsite inspection at Waterview Home. I also contacted the assigned Office of Recipient Rights (ORR) worker, Amanda Clasman. On 08/25/23, I received additional allegations that staff failed to schedule a psychiatric appointment for Resident B after it was recommended on 05/12/23. The additional allegations also stated that staff have been passing Melatonin to Resident B without a prescription, and that this medication is not listed on his medication administration record.

On 08/10/23, I conducted an unannounced onsite inspection at Waterview Home. I interviewed direct care worker, Anita Simonton. Ms. Simonton stated that she has worked at Waterview Home for about one month. She stated that she was working at the home on 08/03/23 when the police were called to the home due to Resident A's

behavior. Ms. Simonton stated that they were having a barbecue that day and were outside grilling food. Resident A has a tendency to get too close to people and touch or grab them. Ms. Simonton was trying to redirect Resident A and told him to back up. Resident A then started to bother the other staff who were working. When they tried to redirect him, he became upset and was saying, “You don’t tell me what to do.” After they ate, Resident A wanted to do his dishes, but there were a lot of other dishes in the sink still, including sharp knives. Staff asked Resident A to put his dishes down and wait a second until they could clear out the sink for him. Resident A’s behavior escalated again, and he began cussing out staff and saying that they could not tell him what to do. Staff were trying to redirect Resident A. He was walking towards his room and shoved Resident C, who is non-verbal. The home manager went outside and called the police. The police came to the home and transported Resident A to the hospital. Ms. Simonton stated that she felt staff responded appropriately in this situation. They did not tell Resident A that he could not wash his dishes, they just asked him to wait until it was safe to do so. Ms. Simonton stated that Resident D was on the couch during this time, but they asked him to go to his room for his safety. The home manager, Danielle Williams, and staff, Centourria Gipson, were on shift with Ms. Simonton on the date of the incident. At the time of my onsite inspection, Resident A was at an appointment and was not available to be interviewed.

On 08/10/23, I interviewed Resident D. Resident D stated that Resident A has behavior issues sometimes. Resident D typically goes to his room or goes outside when Resident A is having a behavior. He did not recall a time when staff told Resident A that he could not do his dishes. Resident D stated that staff are good and treat Resident A okay. He did not have any concerns about anything in the home.

On 08/24/23, I interviewed the home manager, Danielle Williams, via telephone. Ms. Williams stated that she has worked at the home since January 2022. Ms. Williams stated that on 08/03/23, they were having a cookout and were grilling food outside. After dinner, Resident A went to wash his plate, and she asked him to put his dishes on the counter and wait a minute, because there were other dishes in the sink, including sharps. Resident A became upset and pushed another resident. Staff tried to redirect Resident A many times, but he was getting angrier, and his behavior continued to escalate. Ms. Williams stated that she stepped outside and called the police. Ms. Williams stated that Resident A’s plan of service states that he is allowed to wash his own dishes, but he can only wash his dishes if there are no sharps around. Resident A previously chased staff around the house with a knife, so he is not permitted access to sharp objects. Ms. Williams stated that she believed everyone responded appropriately in this situation. All of the staff remained calm with Resident A, and nobody raised their voices. She did not tell Resident A that he could not do his dishes, she just asked him to wait a moment due to the sharps in the sink and his previous behaviors.

On 08/28/23, I conducted an unannounced onsite inspection at Waterview Home. I interviewed the medication coordinator, Centourria Gipson. Ms. Gipson stated that she was working with Anita Simonton and Danielle Williams on 08/03/23 when the police were called to the home due to Resident A’s behaviors. She stated that Resident A had

a good morning, but later in the day they were barbecuing, and Resident A started having behaviors. He was trying to get in her space and pick at her in an attempt to get a reaction from her. After dinner, Resident A brought his dishes into the kitchen and asked to wash his plate. The home manager, Danielle Williams, told him to give her a minute because there were sharps in the sink. Resident A is not allowed to be around sharps due to past behaviors. Ms. Gipson stated that the home manager did not tell him he could not do his dishes, she just asked him to wait a minute. Resident A's behavior escalated. The other staff, Anita Simonton, was able to calm Resident A down, but then as he was walking towards his room, he pushed another resident. The home manager stepped into the garage and called the police due to Resident A's aggressive behavior.

On 08/28/23, I interviewed Resident A. Resident A stated that he remembered the day when the police came to the home. He stated that he got into a fight with the home manager, Danielle. Resident A stated that he did not know why they were fighting. He does not like it when she calls the cops on him. He stated that they were having a barbecue that day and nothing happened that made him mad. Staff said he pushed one of his housemates, but he did not put his hands on her. Resident A stated that after they are done eating, he is allowed to wash his own dishes. Danielle would not let him wash his dishes that day. She told him to set his dishes down and did not give him a reason why he could not wash them. He then stated that she said there was other stuff in the sink. Resident A stated that he likes living at Waterview Home and he usually gets along with Danielle. He stated that the staff treat him well and Danielle is his favorite staff. Resident A stated that he has not had any problems since that day, and he does not have any other concerns about the home.

I reviewed a copy of Resident A's individual plan of service (IPOS) effective from 03/01/23-02/29/24. It notes that with verbal prompting, Resident A will complete household tasks at least four times a week for 75% of trials for the next 12 months. Resident A will work on household chores to the best of his ability. This includes clearing his plate and his housemate's plates from the table after dinner, loading the dishwasher, folding laundry, and taking out the trash. Resident A's plan notes that he has a restriction for locked sharps and that sharps and medications should be locked up or out of reach.

I reviewed a copy of an incident report dated 08/03/2023. It notes that Resident A became upset when staff (Danielle) asked him to set his plate on the counter, because staff was cleaning up the kitchen and there were already dishes in the sink. As Resident A was walking away, he pushed another resident. Staff tried to redirect Resident A many times but called 911 due to his aggressive behavior towards staff and other residents in the home.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that staff did not follow Resident A's written assessment plan. Staff were attempting to ensure Resident A's safety when they asked him to wait a moment to do his dishes, because there were other dishes, including sharp knives, in the sink. While Resident A's individual plan of service notes that he has a goal of completing household chores, including clearing his dishes and loading the dishwasher, it also notes that sharps should be locked up or out of reach. Staff were trying to keep Resident A safe by ensuring that the sharp objects in the sink were not within his reach. All of the staff who were interviewed stated that they did not tell Resident A that he could not wash his dishes but asked him to wait until the sink was cleared.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Staff failed to schedule a psychiatric appointment for Resident B after it was recommended on 05/12/23. Staff were passing Melatonin to Resident B, but there was no prescription in the home and this medication is not listed on his medication administration record.

INVESTIGATION:

On 08/25/23, I received additional allegations that staff failed to schedule a psychiatric appointment for Resident B after it was recommended on 05/12/23. The additional allegations also stated that staff have been passing Melatonin to Resident B without a prescription, and that this medication is not listed on his medication administration record (MAR).

On 08/25/23, I contacted the assigned Office of Recipient Rights (ORR) worker, Rishon Kimble. Ms. Kimble provided additional information that the nurse from Easter Seals, Libby Menendez, visited the home on 07/24/23. Resident B was receiving Melatonin, but the nurse did not see a prescription in the home, and it was not listed on the MAR. The nurse told staff at the home that they cannot give Resident B Melatonin without a prescription and without it being listed on the MAR. She advised the assistant manager

to contact the pharmacy to get the information added to the MAR. The nurse visited the home again on 08/17/23 and saw that the Melatonin was still not listed on the MAR and there was no prescription. The nurse also stated that an appointment record from Resident B's primary care physician indicated that he needed to see a psychiatrist for his increased agitation. There was no record that this was completed. The nurse followed up with the home manager and assistant home manager on 06/26/23, 07/24/23, and 08/17/23 regarding the psychiatric appointment. As of 08/22/23, there was no confirmation that the psychiatric appointment was scheduled.

The home manager, Danielle Williams, stated that Resident B has been taking Melatonin since June of 2023. She could not recall the exact date it was prescribed. She stated that the medication was not listed on the August MAR, because she may have forgotten to print it out, but the medication is listed on the MAR now. Ms. Williams stated that the medication coordinator handles appointments and should have called to get a referral from the doctor for a psychiatric appointment at Bald Mountain. Last year, Bald Mountain said that Resident B did not need therapy. Ms. Williams was not sure if the medication coordinator attempted to schedule an appointment, but she thought she contacted the doctor for a referral within the last week. Resident B has not been seen by a psychiatrist yet.

On 08/28/23, I conducted an unannounced onsite inspection at Waterview Home. I interviewed the medication coordinator, Centourria Gipson. Ms. Gipson stated that the nurse from Easter Seals came to the home last week and was very rude. The nurse mentioned that Resident B had not seen the psychiatrist yet. Ms. Gipson called to schedule the appointment while the nurse was in the home, but the psychiatrist's office stated that they do not deal with dementia and that they would have to contact the insurance company to find a different provider. An appointment has not yet been scheduled. Ms. Gipson stated that she did not know when Resident B was initially referred to see the psychiatrist and was not sure where the nurse got the information about the referral. She stated that the nurse indicated that the referral was made in April, but Ms. Gipson was not working at the home in April. She stated that she did not know why the psychiatric appointment was not scheduled. Resident B has not seen a psychiatrist since she has been working in the home. He only sees his primary care physician and neurologist.

Ms. Gipson stated that Resident B is prescribed Melatonin through his primary care physician. She provided a copy of the prescription for Melatonin 10mg- take one tablet every night at bedtime, which was written on 06/14/23. She provided a copy of Resident B's August 2023 Medication Administration Record (MAR), which showed Melatonin 10mg- take one tablet by mouth at bedtime, which was added to the MAR on 08/17/23. Staff initialed the MAR for the Melatonin from 08/17/23-08/27/23. I observed Resident B's bubble pack for Melatonin 10mg. It was filled on 07/11/23 and staff began passing pills from the bubble pack on 08/01/23. There were 27 pills administered from the bubble back and four pills remaining for the month. Ms. Gipson stated that although she is the medication coordinator, the home manager is responsible for typing out the MAR each month and making sure all the medications are listed on the MAR. She stated that

staff do their five rights when passing medications and check the label and the MAR. She could not explain why she or other staff would have passed the medication if it was not listed on the MAR from 08/01/23-08/16/23. She later stated that she told the home manager it was missing from the MAR on the first of the month and did not know why it was not added to the MAR at that time. She could not locate Resident B's July MAR to see if the medication was listed.

I observed Resident B in the home. He was sleeping in his bedroom. Ms. Gipson advised against waking him up, as she stated that he gets very agitated. Ms. Gipson stated that Resident B typically sleeps during the day and then will be up all night hollering, which is why he was prescribed Melatonin.

I reviewed a copy of a communication record from Resident B's physician through Harmony Cares Medical Group. The visit date is 05/12/23. The record states, "Please schedule appointment with Bald Mountain Behavioral Medicine-Lake Orion Counseling to address agitation, confusion, etc."

On 10/06/23, I attempted to conduct an exit conference via telephone with the licensee designee, Paula Barnes. Ms. Barnes was not available, so I left a message.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: (d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that staff at Waterview Home did not follow the recommendations of Resident B's physician. On 05/12/23, Resident B's physician recommended that an appointment be scheduled with Bald Mountain Behavioral Medicine for a psychiatric appointment due to increased agitation and confusion. The nurse from Easter Seals followed up with home staff several times regarding the appointment, but as of 08/28/23 the psychiatric appointment had not been scheduled for Resident B.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 the information gathered through my investigation, there is insufficient information to conclude that staff were giving Resident B Melatonin without a prescription from a licensed physician. Although the medication was not listed on Resident B's medication administration record, the medication coordinator provided a copy of the prescription which shows that on 06/14/23 Resident B was prescribed Melatonin 10mg- take one tablet every night at bedtime. I observed the medication bubble pack in the home, which was provided by the pharmacy. The label instructions on the bubble pack matched the prescription.
CONCLUSION:	VIOLATION NOT ESTABLISHED

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. (iii) Label instructions for use. (iv) Time to be administered. (v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.

ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Melatonin 10mg was not listed on Resident B's August 2023 Medication Administration Record (MAR) from 08/01/23-08/16/23. Staff did not initial the MAR from 08/01/23-08/16/23, but the medication was passed from the bubble pack. The home manager added the medication to the MAR on 08/17/23.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Renewal Licensing Study Report Dated: 10/28/21; CAP Dated: 11/08/21; SIR # 2021A0611027 Dated: 10/08/21**; **CAP Dated: 10/21/21.**

IV. RECOMMENDATION

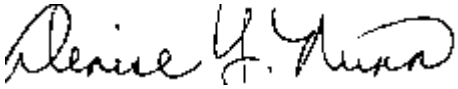
Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.

10/06/2023

_____

Kristen Donnay Date
Licensing Consultant

Approved By:



10/13/2023

_____

Denise Y. Nunn Date
Area Manager