GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 2, 2024

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

RE: License #: AS630405663
Investigation #: 2024A0611007
Seymour Home

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 (248) 975-5053.

Sincerely,

Sheena Worthy, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630405663
Investigation #:	2024A0611007
Complaint Receipt Date:	12/01/2023
Investigation Initiation Date:	12/06/2023
Report Due Date:	01/30/2024
Licensee Name:	Central State Community Services, Inc.
Licensee Address:	Suite 201 - 2603 W Wackerly Rd Midland, MI 48640
Licensee Telephone #:	(989) 631-6691
Administrator:	Paula Barnes
Licensee Designee:	Paula Barnes
Name of Facility:	Seymour Home
Facility Address:	241 Cheltenham Oxford, MI 48371
Facility Telephone #:	(248) 572-6040
Original Issuance Date:	03/04/2021
License Status:	1ST PROVISIONAL
Effective Date:	09/01/2023
Expiration Date:	02/29/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Staff Johnathan Phinisee administered the wrong medications to Resident F on 11/24/23.	Yes

III. METHODOLOGY

12/01/2023	Special Investigation Intake 2024A0611007
12/06/2023	Special Investigation Initiated - Letter An email was sent to recipient rights specialist Kathleen Garcia regarding additional information.
12/06/2023	Contact - Document Received I received an email response from the recipient rights specialist, Kathleen Garcia regarding Resident F.
12/14/2023	Contact - Document Received The recipient rights specialist Kathleen Garcia sent me a copy of a incident report, hospital discharge information, a copy of staff member Johnathan Phinisee medication training, Resident F and Resident M MAR record, a copy of the 8 rights, and a staff schedule.
12/19/2023	Inspection Completed On-site I interviewed the home manager, Regina Wheaton and Resident A. I received a copy of Resident F December MAR.
12/21/2023	Contact - Telephone call made I made a telephone call to staff member, Tiffany Jones. The allegations were discussed.
12/21/2023	Contact - Telephone call made I made a telephone call to staff member, Johnathan Phinisee. The allegations were discussed.
12/21/2023	Exit Conference I completed an exit conference with the program manager, Jamila Banister as the licensee designee Paula Barnes did not answer her phone. Ms. Barnes has provided written permission to have Ms. Banister act on her behalf.

ALLEGATION:

Staff Johnathan Phinisee administered the wrong medications to Resident F on 11/24/23.

INVESTIGATION:

On 12/01/23, a complaint was received and assigned for investigation alleging that staff member Johnathan Phinisee administered the wrong medications to Resident F on 11/24/23. The resident's medications that were administered were Resident M. The wrong medications that were administered to Resident F was Citracal CAL+D, Vyvanse 30mg, Propranolol 40mg, Depakote 500mg, Lorazepam 1mg, Geodon 40mg, Risperdal 2mg, and Sertraline 100mg. As a result of the medication error, Resident F was transported to the hospital.

On 12/05/23, this case was reassigned to licensing consultant Sheena Worthy.

On 12/06/23, I received the following email response from the recipient rights specialist, Kathleen Garcia:

> *"My understanding was that no, the individual served did not have any adverse effects as a result of being administered the incorrect medications, that the individual was transported to the hospital as a precaution".*

On 12/14/23, the recipient rights specialist Kathleen Garcia sent me a copy of an incident report, hospital discharge information, a copy of staff member Johnathan Phinisee medication training, Resident F's and Resident M's MAR record, a copy of the 8 rights, and a staff schedule.

The date of the incident is 11/24/23. The incident report was completed by Annette Perry. The incident is involving staff member Johnathan Phinisee and Resident F. According to the incident report, staff administered Resident M's medications to Resident F. The wrong medications that were given to Resident F were Citracal CAL = D, Vyvanse 30mg, Propranolol 40mg, Depakote 500mg, Lorazepam 1mg, Geodon 40mg, Risperdal 2mg, Sertraline 100mg. The staff called the program manager, program coordinator, and a supervisor to report the incident. Resident F was transported to the hospital by an ambulance.

According to Resident F hospital discharge information, she was seen at Trinity Health on 11/24/23 by Dr. C. Cooper, MD. Resident F was seen for altered mental status. Resident F diagnosis was adverse effect of drug, initial encounter. Information was provided regarding depression medicine side effects.

According to staff member Johnathan Phinisee training certificate, he completed the following trainings on 06/18/22. The certificate indicates that Mr. Phinisee completed the

requirements for the specialized residential service providers training provided by Macomb County Community Mental Health. The trainings included on the certificate are as follows: introduction to human services and meeting special needs, person-centered planning, crisis planning, documentation skills, behavior and crisis, trauma informed services, suicide risk assessment and intervention, building natural supports, human relationships, nutrition, food safety, philosophy and current trends, environment emergency preparedness, teaching new skills, health and wellness, medication, medication administration, transcription of MAR. At the bottom of the certificate, it indicates that this certificate is not validation of completing an in-person health and medication demonstration.

According to Resident F's MAR for the month of November, the initials "JP" was documented on 11/24/23 with a circle around the initials for all of Resident F's morning medications. According to Resident M's MAR for the month of November, the initials "JP" was documented on 11/24/23 for all of Resident M's morning medications.

I observed the staff schedule for 11/18/23 through 11/24/23. Mr. Phinisee worked the dayshift on 11/24/23 from 7:00am to 7:00pm. Staff member, Tiffany Jones also worked the dayshift on 11/24/23 starting at 9:00am.

On 12/19/23, I completed an unannounced onsite. I interviewed the home manager, Regina Wheaton and Resident A. I received a copy of Resident F's December MAR. Ms. Wheaton stated Resident A is the only resident who has the capability to be interviewed.

On 12/19/23, I interviewed the home manager, Regina Wheaton. Regarding the allegations, Resident F went to the hospital on 11/24/23 as a precaution after staff member Johnathan Phinisee administered the wrong medications to Resident F. Mr. Phinisee gave Resident M's medications to Resident F. Ms. Wheaton stated Resident F was sent home from the hospital on the same day (11/24/23) as the doctor stated she was fine. The doctor instructed for staff to look out for side affects such as drowsiness. Ms. Wheaton stated Resident F was drossy, but the doctor said it will wear off in about 3-4 hours. Ms. Wheaton stated the drowsiness did wear off but, Resident F was looking sick, she wasn't talking or moving around. Resident F could not walk, and she required total care.

Ms. Wheaton stated Mr. Phinisee has worked for the AFC group home for about four months. Mr. Phinisee quit his job either on 12/14/23 or 12/15/23 due to not having transportation after he was in a car accident. Mr. Phinisee's last day of work was on 11/30/23. Ms. Wheaton does not know if Mr. Phinisee received any disciplinary action for administering the wrong medications to Resident F. Mr. Phinisee did not provide an explanation as to how he administered the wrong medications. Mr. Phinisee's only response was that it was an accident. Ms. Wheaton stated Resident M was still administered her morning mediations on 11/24/23 because the pharmacy was called about the error, and they delivered another set of morning medications for Resident M

on 11/24/23. Ms. Wheaton stated she was not present when Mr. Phinisee administer the wrong medications.

On 12/19/23, I interviewed Resident A. It appeared that Resident A did not understand some of the questions that were asked. Resident A stated he likes living at the AFC group home as well as the staff members. Resident A confirms that he takes medication. Resident A stated he takes a blue pill every day. Resident A could not say who gives him this medication. Resident A stated he is taken care of by staff. Resident A bathes himself and has clean clothes.

On 12/21/23, I made a telephone call to staff member, Tiffany Jones. Regarding the allegations, Ms. Jones stated on 11/24/23 she worked from 9:00am to 7:00pm. Ms. Jones stated when she arrived to work on 11/24/23, Mr. Phinisee had already administered the 8:00am medications to Resident F. Mr. Phinisee was on the phone with upper management as he was informing them about the medication error he made. Ms. Jones stated after Mr. Phinisee spoke to upper management, he was advised not to administer anymore morning medications to the other residents. Therefore, she does not believe Mr. Phinisee administered Resident F her prescribed morning medications after he gave her the wrong medications.

Ms. Jones stated Mr. Phinisee called 911 and accompanied Resident F to the hospital when the ambulance arrived. Ms. Jones described Resident F's disposition before she went to the hospital as loopy. Resident F is not use to taking psychotropic medications as she is only prescribed medications for her blood pressure and vitamins. Resident F did not vomit or spit up before she went to the hospital. Ms. Jones stated Resident F was laughing before she went to the hospital. Ms. Jones was present at the AFC group home when Resident F returned from the hospital on the same day. Ms. Jones stated Mr. Phinisee has never made this mistake before. Ms. Jones believes that Mr. Phinisee is trained to administer medications as he was a few steps ahead of her and she thinks he completed his medication in-person demonstration. Ms. Jones stated she has worked for the AFC group home for three years however; last year the home switched to a new training program through Easter Seals, and she had to complete the entire training process over.

Ms. Jones stated the home manager from Waterview, Annette Perry came to the AFC group home and administered the remaining morning medications to the residents. Ms. Jones believes that Ms. Perry administered Resident M morning medications from the next day and then contacted the pharmacy and had them deliver an emergency refill for the missing medications.

On 12/21/23, I made a telephone call to staff member, Johnathan Phinisee. Mr. Phinisee stated he quit his job on 12/14/23 as he no longer had transportation after being in a car accident. Mr. Phinisee stated on 11/24/23 he was in the process of administering Resident M her medications but, he looked at Resident F's name in the MAR book and gave Resident F Resident M's medications. Mr. Phinisee noticed the error when he returned to the MAR book. Mr. Phinisee stated he has never made this

mistake before. Mr. Phinisee contacted supervisor Annette Perry. Ms. Perry advised him to call 911. Mr. Phinisee contacted 911 and also informed the administrator Kimberly Iston and the program manager Jamilla Banister. Mr. Phinisee stated after he administered Resident F the wrong medication, Resident F was talking at first and then she started starring at the ceiling. Resident F did not throw up after she was given the wrong medication. Mr. Phinisee accompanied Resident F to the hospital. Mr. Phinisee stated Resident F returned to the home the same day but, he cannot remember if he returned back to the home after he left the hospital because he was traumatized. Mr. Phinisee stated when he arrived to work the next day, Resident F was still starring at the ceiling and; continued to stare at the ceiling the following day. Mr. Phinisee notified management but he doesn't remember who. Mr. Phinisee then stated he informed Ms. Wheaton, Ms. Iston, and Ms. Banister of his observation. As a result, Resident F was taken to the hospital again as a precaution.

Mr. Phinisee stated he was trained to administer medications at the Waterview group home over a year ago. Mr. Phinisee stated while working at Seymour Home he was informed that he had to complete the medication training again. Mr. Phinisee stated he did not fully complete the medication training classes while at Seymour Home. Mr. Phinisee stated he was expected to complete the trainings while he was working however; he would get too busy. Mr. Phinisee stated Ms. Perry observed him in-person administering medications three times in one day and two times a different day. Mr. Phinisee was given permission by Ms. Perry to administer medications. Mr. Phinisee stated he was not disciplined after he made the medication error because management was supposed to have continued observing him while he was passing medications.

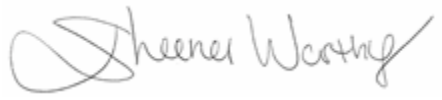
On 12/21/23, I completed an exit conference with the program manager, Jamilla Banister who has permission from the licensee designee, Paula Barnes to act of her behalf. Ms. Banister provided a copy of a medication check-off quick sheet. The medication check-off quick sheet documented the number of times Ms. Perry observed Mr. Phinisee administer medications. According to the medication check-off quick sheet, Ms. Perry observed Mr. Phinisee on 11/20/23 at 8:00am, 11/21/23 at 4:00pm, 11/21/23 at 8:00pm, 11/22/23 at 8:00am, 11/22/23 at 4:00pm, and 11/22/23 at 8:00pm. Mr. Banister confirmed that Mr. Phinisee did complete his medication training in Macomb County prior to working at Seymour Home. Ms. Banister stated Mr. Phinisee was not written up because it is the AFC group home policy not to issue discipline until they know the outcome of the recipiient rights/licensing investigations. Ms. Banister stated it is the AFC group home policy to observe a staff member 4 or 5 times administering medications before they can administer by themselves. Ms. Banister stated that requirement was fulfilled with Mr. Phinisee.

Ms. Banister stated after Resident F returned to the home on 11/24/23, she was informed that Mr. Phinisee was saying that Resident F was not acting like herself. As a result, Resident F was taken back to the hospital, and she was diagnosed with a UTI.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Mr. Phinisee confirmed that he administered Resident F the wrong morning medications on 11/24/23. Mr. Phinisee administered Resident M's medications to Resident F. As a result, Resident F was transported to the emergency room and was later discharged the same day.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

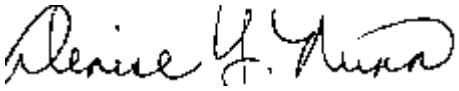
A previous recommendation for a 1st provisional license was made in Licensing Study Report (LSR) dated 09/01/23, which remains in effect. Contingent upon receipt of an acceptable corrective action plan, this investigation will be closed.



Sheena Worthy
Licensing Consultant

12/21/23
Date

Approved By:



01/03/2024
Date

Denise Y. Nunn
Area Manager