GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 8, 2021

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

RE: License #: AS630407345
Investigation #: 2021A0611027
Waterview Home

Dear Ms. Ott:

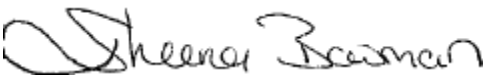
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 Bowman, 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 #:	AS630407345
Investigation #:	2021A0611027
Complaint Receipt Date:	08/11/2021
Investigation Initiation Date:	08/18/2021
Report Due Date:	10/10/2021
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 Ott
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:	TEMPORARY
Effective Date:	05/18/2021
Expiration Date:	11/17/2021
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident M did not have her Clonazepam (Klonopin) for the entire month of July 2021. However, it had been signed off as being passed during the month of July.	Yes

III. METHODOLOGY

08/11/2021	Special Investigation Intake 2021A0611027
08/18/2021	Special Investigation Initiated - Letter I sent an email to recipient rights specialist Rishon Kimble regarding the allegations.
08/24/2021	Contact - Face to Face I completed an unannounced onsite. I interviewed staff member, Sheena Vickery, staff member Georgia Hawkins, and I received copies of Resident M's MAR, and I reviewed some of the residents HCC, CLS logs, and goal sheets.
09/03/2021	Contact - Document Sent I sent an email to recipient rights specialist Rishon Kimble to inquire about the outcome of her investigation.
09/03/2021	Contact-Document Sent I received an email from Rishon Kimble. Ms. Kimble stated she has not completed her investigation.
09/03/2021	Exit Conference I completed an exit conference with the licensee designee, Paula Ott via email.

ALLEGATION:

Resident M did not have her Clonazepam (Klonopin) for the entire month of July 2021 however; it had been signed off as being passed during the month of July.

INVESTIGATION:

On 08/24/21, I completed an unannounced onsite. I interviewed staff member, Sheena Vickery, staff member Georgia Hawkins, and I received copies of Resident M's MAR, I observed Resident M's Clonazepam bubble packets, and I reviewed some of the resident's health care chronological (HCC), community living support (CLS) logs, and goal sheets.

On 08/24/21, I interviewed staff member, Sheena Vickery. Regarding the allegations, Ms. Vickery stated Resident M did not receive her Clonazepam from August 1st through August 5th as her prescription was not refilled. Resident M is prescribed Clonazepam three times a day. I observed Resident M's Clonazepam bubble packet for 5:30am, 12:00pm, and 8:00pm. The bubble packet for 5:30am had Clonazepam pills still in the bubble packet from August 1st through August 5th. The bubble packet for 12:00pm had Clonazepam pills still in the bubble packet from August 1st through August 4th. The bubble packet for 8:00pm had Clonazepam pills still in the bubble packet from August 1st through August 4th.

Ms. Vickery stated on July 1, 2021, she was working the midnight shift. When it was time for Ms. Vickery to administer the resident's morning medications, she noticed Resident M's Clonazepam was missing. Ms. Vickery contacted the home manager, Georgia Hawkins and informed her that Resident M's Clonazepam was not in the AFC group home. Ms. Hawkins stated she will call the pharmacy to find out why the Clonazepam was not delivered to the AFC group home. Ms. Vickery stated Resident M was not administered her Clonazepam for the entire month of July 2021 as her prescription was not refilled until August 5, 2021. Ms. Vickery stated Resident M's neurologist doctor refused to refill Resident M's Clonazepam because Resident M had missed several of her doctor appointments during the month of March and May 2021. An appointment for Resident M to see the neurologist was scheduled for August 18th. Ms. Hawkins contacted Resident M's primary care physician to get a prescription for the Clonazepam until August 18th.

On 08/24/21, I interviewed the home manager, Georgia Hawkins. Ms. Hawkins has been the home manager since July 7, 2021. Regarding the allegations, Ms. Hawkins stated Ms. Vickery informed her that Resident M's Clonazepam was missing. Ms. Hawkins contacted the pharmacy and Resident M's doctor to get a new prescription. Ms. Hawkins stated she could not obtain a new prescription because Resident M had missed her neurologist appointments. A new appointment was scheduled for Resident M to see her neurologist doctor on August 19, 2021. Ms. Hawkins contacted Resident M's primary care physician and received a prescription for the Clonazepam. Ms. Hawkins stated she does not know why Resident M was missing her neurologist appointments. Resident M is supposed to see her neurologist every 3-6 months.

Ms. Hawkins stated she does not know why the residents' documents were not being completed by staff. A staff meeting was held on or about August 10, 2021, about missing documents. Ms. Hawkins stated a lot of employees didn't know they were supposed to fill out the health care chorological. Ms. Hawkins stated the CLS logs document what is going on each day with the residents. The goal sheets indicate if a resident has completed a goal each day. The goal sheets have to be encrypted in a zip file. Ms. Hawkins stated all of the resident's goal sheets are encrypted except for Resident D. Ms. Hawkins stated once she receives an encrypted email from Resident D's support coordinator, she will have the goal sheets for Resident D.

On 08/24/21, I received a copy of Resident M's MAR for the month of July 2021. Regarding Resident M's Clonazepam, there were no staff initials on the MAR for the 12:00 pm dosage on 7/4/21, 7/16/21, or 7/25/21. Regarding the 5:30am dosage, there were no staff initials on 7/9/21, 7/21/21. Regarding the 8:00pm dosage, there were no staff initials on 7/1/21, 7/6/21, 7/7/21, or 7/10/21. However, per the comments on the back of the MAR, the Clonazepam was not in the home for the majority of the month. The comments also indicated that Resident M was in the hospital on 7/7/21, 7/8/21, and 7/10/21. However, the dates on the comment page that state which days Resident M was in the hospital does not coincide with the initials that say Resident M was in the hospital on the MAR. For instance, regarding Clonazepam, the MAR indicates that Resident M was in the hospital on 7/11/21 and 7/12/21 however; per the comments Resident M was not hospitalized again until 7/13/21 through 7/15/21. This discrepancy was also observed regarding Resident M's Melatonin and Baclofen. There are several missing staff initials consistently throughout the MAR regarding Resident M's weight record, Amox-k clav, Vitamin D, Mirtazapine, Enulose, Multi-VITE, and Erythromycin.

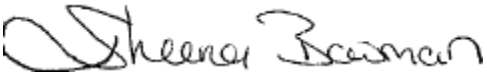
On 09/03/21, I completed an exit conference with the licensee designee, Paula Ott via email. Ms. Ott was informed that the allegations will be substantiated and a corrective action plan will be required.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident M is prescribed Clonazepam three times a day. Ms. Vickery and Ms. Hawkins confirmed that Resident M was not administered her Clonazepam during the month of July 2021. Resident M did not start receiving her Clonazepam until August 5, 2021.
CONCLUSION:	**VIOLATION 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:** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	According to Resident M's MAR for the month of July 2021, there were several missing staff initials consistently throughout the MAR regarding Resident M's weight record, Amox-k clav, Vitamin D, Mirtazapine, Enulose, Multi-VITE, and Erythromycin. Although the comments on the back of the MAR indicated that Resident M's Clonazepam was not in the home, there were several staff initials on the MAR indicating the medication was being administered.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

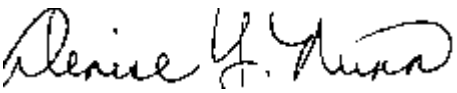


09/03/21

Sheena Bowman
Licensing Consultant

Date

Approved By:



10/08/2021

Denise Y. Nunn
Area Manager

Date