GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 8, 2021

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

RE: License #: AS250291671
Investigation #: 2022A0569006
Vassar Road 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 (517) 284-9730.

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 #:	AS250291671
Investigation #:	2022A0569006
Complaint Receipt Date:	11/04/2021
Investigation Initiation Date:	11/04/2021
Report Due Date:	01/03/2022
Licensee Name:	Central State Community Services, Inc.
Licensee Address:	Suite 201 2603 W Wackerly Rd Midland, MI 48640
Licensee Telephone #:	(989) 631-6691
Administrator:	Regina Wheaton
Licensee Designee:	Paula Ott
Name of Facility:	Vassar Road Home
Facility Address:	3220 Vassar Road Burton, MI 48519
Facility Telephone #:	(810) 742-2745
Original Issuance Date:	09/12/2007
License Status:	REGULAR
Effective Date:	04/22/2020
Expiration Date:	04/21/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

	MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
• **Two staff were observed sleeping in their cars on 11/3/21, leaving the residents unsupervised.**	Yes
• **Resident A was not administered several prescribed medications during October 2021.**	Yes
• **Resident A's medication administration logs were not maintained for September and October 2021.**	Yes

III. METHODOLOGY

11/04/2021	Special Investigation Intake 2022A0569006
11/04/2021	APS Referral
11/04/2021	Special Investigation Initiated - Letter Email from Michelle Salem, RRO.
12/06/2021	Contact - Telephone call made Contact with Michelle Salem, RRO.
12/06/2021	Inspection Completed On-site
12/06/2021	Contact - Telephone call made Contact with Penelope Tohm, GHS case worker.
12/06/2021	Contact - Telephone call made Contact with Raheem Riley, staff person.
12/06/2021	Contact - Telephone call made Attempted contact with Jaylin Coward, staff person. No answer. Voicemail was full and could not take messages.

12/06/2021	Inspection Completed-BCAL Sub. Compliance
12/08/2021	Exit Conference Exit conference with Paula Ott

ALLEGATION:

Two staff were observed sleeping in their cars on 11/3/21, leaving the residents unsupervised.

INVESTIGATION:

This complaint was received via the on-line complaint portal and email information. The complainant reported that the two staff working on 11/3/21 were observed in vehicles in the driveway of the facility leaving the residents unsupervised inside of the facility.

An unannounced inspection of this facility was conducted on 12/6/21. Breonshay Hatten, home manager, was present. Ms. Hatten stated that she has been on maternity leave from July 2021 to mid-November 2021. Ms. Hatten stated that she was not present when this incident occurred. Ms. Hatten stated that the two staff working on 11/3/21 during the first shift were Raheem Riley and Jaylin Coward.

On 12/6/21, Resident A was alert and oriented to person, place, and time. Resident A was appropriately dressed and groomed with no visible injuries. Resident A stated that he did remember that staff were not in the facility “about a month ago” but did not recall the specific date. Resident A stated that he did not remember which staff were working, but that he remembered that both staff had gone out to the driveway. Resident A stated that one of the staff was in his own car, and he did not remember where the other staff person went. Resident A stated that the residents were not being supervised “by anyone” for “maybe an hour”. Resident A stated that “it could have been less, but at least 30 minutes”. Resident A stated that none of the residents were injured in any way and that the staff “eventually” came back into the facility.

On 12/6/21, Resident B was alert and oriented to person, place, and time. Resident B was appropriately dressed and groomed with no visible injuries. Resident B stated that he remembered a day when all of the residents were in the facility and there were no staff. Resident B stated that this incident occurred “not too long ago”. Resident B stated that he thinks that the staff went out to the driveway. Resident B stated that the staff were gone for “a while” but didn’t know exactly how long. Resident B stated that no residents were injured when this occurred.

Penelope Tohm, GHS staff person, stated on 12/6/21 that she arrived at the facility on 11/3/21 at about 3:30pm and parked her car right beside a staff person's car and observed a staff person in the front seat with the seat reclined. Ms. Thom stated that she got out of her car and slammed the door closed but there was no response from the staff person. Ms. Thom stated that she then opened the door to the back seat of her car to get her computer, then slammed the back door closed and the staff person still did not move. Ms. Thom stated that she then looked at the facility van and observed a second staff person in the front seat which was reclined. Ms. Thom stated that she purposely "made a lot of noise" and neither staff person moved or responded in any way. Ms. Thom stated that she then entered the facility and found all of the residents alone with no other staff person present. Ms. Thom stated that it was "at least" 10 minutes before one of the staff in the driveway entered the facility.

Raheem Riley, staff person, stated on 12/6/21, that he was working at this facility with Jaylin Coward on 11/3/21. Mr. Riley stated that he had received a phone call from his bank, and needed to return the phone call, so he told Mr. Coward that he was going out to his car to make a phone call. Mr. Riley stated that he was not aware that Mr. Coward had walked out of the facility and gotten into the van. Mr. Riley stated that when "the case worker" arrived at the facility, he got out of his car and walked back into the facility. Mr. Riley stated that he was not aware that the residents were left unsupervised, and it was only for a "couple of minutes".

An attempted contact with Mr. Coward was made on 12/6/21. Mr. Coward did not answer the phone call and a recorded message stated that the voicemail was full, and no message could be left.

Michelle Salem, recipient rights officer, stated on 12/6/21 that she investigated this allegation. Ms. Salem stated that she interviewed Resident A and Resident B and they gave the same statements to her. Ms. Salem stated that Mr. Riley had stated that he went to his car to call his bank and told Mr. Coward that he would be outside. Ms. Salem stated that Mr. Coward reported that he went out to the facility van to wait for a resident to be dropped off at the facility from program and that Mr. Riley never told him that he was going out to his car. Ms. Salem stated that she has cited a recipient rights violation for leaving the residents unsupervised.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	The complainant reported that the two staff working on 11/3/21 were observed sleeping in their cars, leaving the residents unsupervised inside of the facility. Ms. Thom stated that she also observed the two staff in vehicles in the driveway when she arrived at the facility around 3:30pm on 11/3/21. Ms. Thom stated that both staff were sitting in a reclined position in the vehicles, and after she entered the facility, neither staff returned until at least 10 minutes after she entered the facility. Resident A and Resident B both stated that they remembered this incident and that the staff had left the residents unsupervised for possibly up to an hour. Due to the statements given, it is determined that the residents were left unsupervised, and their safety and protection were not attended to. There has been a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A was not administered several prescribed medications during October 2021.

INVESTIGATION:

Ms. Salem stated on 12/6/21 that Resident A did not receive his medication for several weeks in October 2021. Ms. Salem stated that Resident A was admitted to this facility in August 2021 and when his medications ran out, the prescriptions were not refilled for at least two weeks. Ms. Salem stated that Resident B is to receive Clonidine for his blood pressure, and his blood pressure is supposed to be taken prior to giving the medication so if his blood pressure is lower than 90/60, the medications is not to be given. Ms. Salem stated that on 11/1/21 in the morning, 11/3/21 in the morning and 11/3/21 in the evening the medication is popped out of the blister pack, but no initials on medication administration record (MAR) of who administered the medication if in fact it was given. Ms. Salem stated that there was no blood pressure documented prior to giving the medication. Ms. Salem stated that the same thing happened on 11/2/21. Ms. Salem stated that Resident C didn't receive his medication Novolog in the morning of 11/1, or the evenings of 11/1, 11/2, and 11/3. There were no blood sugar measurements written on the MAR either.

Ms. Tohm stated on 12/6/21, that she questioned staff at this facility several times as to why Resident A's medications were no being refilled. Ms. Tohm stated that she was alerted on 11/1/21 of Resident A's medication not being refilled by the staff. Ms. Tohm stated that this issue had been going on for at least 2 weeks. Ms. Tohm stated that the

medications were refilled on 11/2/21 and that she was at the facility when the medications were delivered by the pharmacy. Ms. Tohm stated that the medications as of 11/3/21 at 4pm were still not administered. Ms. Tohm stated that she observed the resident's bubble packs and none of the residents were administered their medications on 11/1/21.

The resident medications were observed during the inspection on 12/6/21. All of the resident bubble packs for December 2021 were current and no medication dosages remained in the packs through the morning doses of 12/6/21. All of the resident MARs were reviewed for October and November 2021. There are currently six (6) residents residing in this facility. The resident MARs document the following dates that at least one of the resident's medications were not administered.

- Resident A: No MAR maintained for October 2021. November 2021- 11/1, 11/3,
- Resident B; October 2021, 10/27, 10/31. Resident B was also administered a blood pressure medication (clonidine) without having his BP monitored first on 10/1, 10/2, 10/12-10/15, 10/17, 10/25, and 10/26. November 2021; 11/5, and 11/7.
- Resident C; no October 2021 MAR in file. November 2021; 11/1, BP medication given without BP monitored first; 11/1-11/8.
- Resident D; 10/10-10/13, 10/18-10/22, 10/27-10/31.
- Resident E; October 2021; 10/1-10/12, 10/26-10/27, 10/29-10/31. November 2021; 11/1.

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:	Ms. Salem and Ms. Tohm both stated that Resident A did not have his prescriptions refilled for at least two weeks and that several of the residents were not given their medications or were not administered the medications correctly for several weeks in October and November 2021. The resident MARs document that Residents were either not administered various medications or were administered medications without first monitoring the residents' BP as directed by the physician. Ms. Tohm stated that she observed the residents' medication bubble packs for October and November 2021 and observed medications left in the bubble packs that had not been administered. Based on the statements given, documentation reviewed, and observations made, it is determined that there has been a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A's medication administration logs were not maintained for September and October 2021.

INVESTIGATION:

Ms. Salem stated on 12/6/21 that Resident A was admitted to this facility in August 2021. Ms. Salem stated that no MAR was maintained for Resident A during October 2021. Ms. Tohm confirmed this statement on 12/6/21.

Resident A's MAR file was reviewed during the inspection on 12/6/21. Resident A's file did not contain any MAR for October 2021. Resident C's file also did not contain a MAR for October 2021.

Ms. Hatten stated that she did not know why a MAR was not maintained for Resident A or Resident C for October 2021. Ms. Hatten stated that she believes that Resident C does have a MAR for October, but she did not know where it was located.

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.** **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	Ms. Salem and Ms. Tohm stated that Resident A did not have a MAR maintained for October 2021. During the inspection on 12/6/21, all of the resident MARs were reviewed. Resident A and Resident C's files were observed to have no MAR for October 2021. Based on the statements given and documentation reviewed, it is determined that there has been a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

An exit conference was conducted with Paula Ott, licensee designee, on 12/8/21. The findings in this report were reviewed.

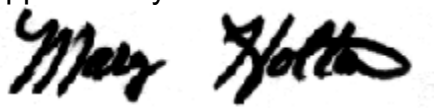
IV. RECOMMENDATION

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

12/8/21

Kent W Gieselman Date
Licensing Consultant

Approved By:



12/8/21

Mary E Holton Date
Area Manager