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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 28, 2022

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

RE: License #: AS250291671
Investigation #: 2022A0569017
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 #:	2022A0569017
Complaint Receipt Date:	01/18/2022
Investigation Initiation Date:	01/19/2022
Report Due Date:	03/19/2022
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?
Resident A was not administered his prescribed Clonazepam from 1/1/22 to 1/4/22.	Yes

III. METHODOLOGY

01/18/2022	Special Investigation Intake 2022A0569017
01/18/2022	APS Referral
01/19/2022	Special Investigation Initiated - Telephone Phone contact with Michelle Salem, RRO.
01/19/2022	Contact - Document Received Email received from Michelle Salem.
02/25/2022	Inspection Completed On-site
02/25/2022	Inspection Completed-BCAL Sub. Compliance
02/28/2022	Exit Conference Exit conference with Paula Ott, licensee designee.

ALLEGATION:

Resident A was not administered his prescribed Clonazepam from 1/1/22 to 1/4/22.

INVESTIGATION:

This complaint was received via the on-line complaint portal. The complainant reported that Resident A is prescribed Clonazepam to control seizures. The complainant reported that Resident A was not administered his Clonazepam from 1/1/22 to 1/4/22. The complainant reported that Resident A did have multiple seizures during this time.

Michelle Salem, recipient rights officer, stated on 1/19/22 that she investigated this complaint. Ms. Salem stated that she determined that Resident A was not administered his Clonazepam from 1/1/22 to 1/4/22, and that he did have multiple seizures as a result. Ms. Salem stated that the Genesee Health System (GHS) nurse determined that Resident A not receiving his medication did pose a threat to his health and Ms. Salem was citing a violation of Resident A's recipient rights requiring a remedial action.

An unannounced inspection of this facility was conducted on 2/25/22. Resident A is non-verbal and could not give a statement regarding this allegation. Resident A was observed to be appropriately dressed and groomed with no visible injuries. Resident A's medical file was reviewed. Resident A's medication administration record (MAR) documents that Resident A is prescribed Clonazepam to control his seizure disorder. Resident A's MAR documents that Resident A was not administered the medication on 1/1/22 to 1/4/22. Resident A's file contains "seizure reports" documenting when Resident A exhibits a seizure. The seizure report contained in Resident A's file documents that Resident A had two seizures on 1/2/22 @ 5:56am and 10:15am, then had two seizures on 1/4/22 @ 10:00am and 9:45pm. Resident A's medication began being administered again on 1/5/22.

Breonshay Hatton, facility manager, stated on 2/25/22 that Resident A's prescription for Clonazepam did run out, and that Resident A did not receive the medication from 1/1/22 through 1/4/22. Ms. Hatton stated that refills for resident medications are usually made a week before the medication runs out, and the pharmacy then delivers the medications to the facility. Ms. Hatton stated that there is usually a staff person designated as the "med coordinator" who is responsible for ensuring the resident medications do not run out, but that there was no one designated as the "med coordinator" when this incident occurred. Ms. Hatton stated that Resident A's prescription ran out on 12/31/21. Ms. Hatton stated that the pharmacy was closed on 1/1/22 and 1/2/22 because of the New Years holiday. Ms. Hatton stated that the pharmacy was then contacted on 1/3/22, but the medication was not delivered until 1/4/22. Ms. Hatton stated that Resident A did have four seizures during this time period.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	The complainant reported that Resident A did not receive his prescribed Clonazepam from 1/1/22 through 1/4/22. The complainant reported that this medication is prescribed to control Resident A's seizure disorder. Ms. Salem, Ms. Hatten, and documentation in Resident A's file all confirmed that Resident A was not administered this medication from 1/1/22 through 1/4/22 and did have four seizures during this time frame. 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 2/28/22. The findings in this report were reviewed.

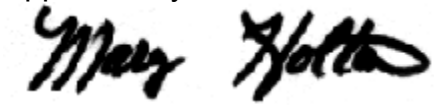
IV. RECOMMENDATION

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

2/28/22

Kent W Gieselman Date
Licensing Consultant

Approved By:



2/28/22

Mary E Holton Date
Area Manager