GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 23, 2024

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

RE: License #: AS250010882
Investigation #: 2024A0779012
Herrington House

Dear Paula Barnes:

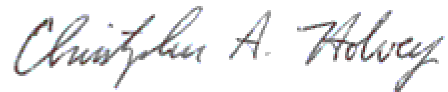
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (517) 643-7960.

Sincerely,



Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250010882
Investigation #:	2024A0779012
Complaint Receipt Date:	12/11/2023
Investigation Initiation Date:	12/13/2023
Report Due Date:	02/09/2024
Licensee Name:	Central State Community Services, Inc.
Licensee Address:	Suite 201 2603 W Wackerly Rd Midland, MI 48640
Licensee Telephone #:	(989) 631-6691
Administrator:	Sharon Butler
Licensee Designee:	Paula Barnes
Name of Facility:	Herrington House
Facility Address:	12168 Lake Road Montrose, MI 48457
Facility Telephone #:	(810) 639-3388
Original Issuance Date:	08/14/1989
License **Status:**	REGULAR
Effective Date:	05/24/2022
Expiration Date:	05/23/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 12/6/23, Resident A was found alone by police in a cornfield.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/11/2023	Special Investigation Intake 2024A0779012
12/11/2023	APS Referral Complaint was referred to AFC licensing by APS.
12/13/2023	Special Investigation Initiated - Telephone Spoke to ORR.
12/14/2023	Inspection Completed On-site
12/14/2023	Contact - Telephone call made Spoke to Saginaw County Sherrif office.
12/14/2023	Contact - Telephone call made Interview conducted with staff person, Delaina Sanders.
01/22/2024	Contact - Telephone call made Spoke to home manager, Shatel Player.
01/22/2024	Contact - Telephone call made Spoke to GHS case manager.
01/22/2024	Exit Conference Held with licensee designee, Paula Barnes.

ALLEGATION:

On 12/6/23, Resident A was found alone by police in a cornfield.

INVESTIGATION:

On 12/13/23, a phone conversation took place with recipient rights investigator, Michelle Salem, who confirmed that she was investigating the same allegations. She stated that per his Individual Plan of Service (IPOS), Resident A is required to have staff supervision while in the community at all times. Investigator Salem reported that there is no mention of Resident A having any elopement history or a need for any enhanced

supervision. Investigator Salem stated that she has spoken to the Saginaw County Sheriff Dept., who confirmed that their dispatch first received a call at 7:54am on 12/6/23 and that they had Resident A in a patrol car by 8:24am. She stated that the Montrose Township Police Dept. told her that the home called them regarding this issue at 11:38am on 12/6/23. Investigator Salem stated that she had already spoken to staff person, Delaina Sanders, who told her that she knocked on Resident A's door two times early that morning with no answer and that she entered Resident A's room just before 11:00am to find the window open and Resident A not in his room. Investigator Salem reported that staff person, Jemetrius Kiff, told her that he worked 3rd shift and last saw Resident A standing in his room at 5:30am.

On 12/14/23, an on-site inspection was conducted, and an attempt was made to interview Resident A. Resident A stated that he does not remember leaving the home or going to the hospital on 12/6/23. Due to his cognitive deficiencies, it is unclear if Resident A fully understood the questioning. When asked if Resident A likes it at this home, Resident A clearly said "No" and shook his head from side to side. Resident A was viewed to be clean, well-groomed, and appeared to be doing fine.

On 12/14/23, administrator, Sharon Butler, stated that Resident A has been at this home for over one year and this was the first time that he has eloped from this home. She stated that she arrived at this home at 10:30am on 12/6/23 and that staff noticed that Resident A was gone at approximately 11:00am. Admin Butler confirmed that the last staff to see Resident A on 12/6/23 was Staff Kiff at 5:30am and that not hearing anything from Resident A for hours is not normal. Admin Butler stated that they called 911 and they sent Montrose Township Police to the home. She stated that while the police were at the home taking their statement, the Saginaw County Sheriff Dept. called the home and reported that they had picked up Resident A and taken him to the hospital. Admin Butler reported that she immediately went to the hospital, found Resident A with no injuries and ready for discharge. Admin Butler stated that she returned to the home with Resident A at approximately 2:30pm. Admin Butler stated that since this incident, they are now checking on Resident A more frequently and if he does not answer his door, staff are going outside to look his window and/or using the key to enter his bedroom.

On 12/14/23, staff person, Lashawntia Robinson, was interviewed. Staff Robinson stated that Resident A is very active and is usually in and out of his bedroom a lot during the day. Staff Robinson stated that Resident A is typically making noise, pacing the floors, hitting walls or yelling. Staff Robinson reported that not seeing or hearing something from Resident A for long periods of time is not normal.

Resident A's *Assessment for Plan for AFC Residents* confirmed that Resident A is not able to be out in the community without staff supervision. The plan states that Resident A requires only minimal staff assistance in order to complete his activities of daily living.

The AFC Licensing Division-Incident/accident Report (IR) that the home provided was quite brief. It simply stated that at 11:00am on 12/6/23, staff entered Resident A's

bedroom to find Resident A missing and his bedroom window open. It stated that staff went looking for Resident A and called 911. The corrective measures listed was for staff to continue to follow Resident A's IPOS and to talk to Resident A's GHS case manager to discuss future plans regarding Resident A.

On 12/14/23, a phone interview was conducted with staff person, Delaina Sanders, who confirmed that she was the staff that worked 1st shift on 12/6/23. Staff Sanders stated that she arrived to work that day at 6:30am and was told by 3rd shift staff that Resident A had already been up for a while. Staff Sanders reported that her first attempt to make contact with Resident A was when she knocked on his bedroom door at 8:00am and that Resident A did not answer. Staff Sanders stated that she knocked on Resident A's door again at 9:30-9:45am and that Resident A did not answer again. Staff Sanders reported that she did not knock on Resident A's door again until 10:30-10:45am and that when he did not answer the door this time, she used the key to unlock and enter Resident A's room. Staff Sanders stated that Resident A had his dresser pushed up against the door and the window was open, but Resident A was missing. Staff Sanders stated that they went out looking for Resident A and then called 911. Staff Sanders stated that she never had eyes on Resident A or heard anything from Resident A before she entered his room and found Resident A missing.

On 12/14/23, a call was made to Sargent Beyerlein of the Saginaw County Sheriff Dept. Sargent Beyerlein confirmed that their dispatch was first called regarding Resident A at 7:54am on 12/6/23 and that an officer had Resident A in the back of a patrol car at 8:24am. She stated that Resident A was found approximately 7 miles from this home. Sargent Beyerlein reported that Resident A was transported to the hospital and that they closed their case once they were able to determine where Resident A lived and had contacted the home.

The discharge papers from the hospital were reviewed. They showed that Resident A entered the ER at 9:25am on 12/6/23 and that he was wearing 7 layers of clothing. After some bloodwork was completed, Resident A was found to be stable, without any known injuries, and discharged at 2:30pm.

On 1/22/24, a phone call made to home manager, Shantel Player. Manager Player stated that Resident A is high behavioral resident and that he will typically yell when staff try to repeatedly check in on him and/or knock on his door. Manager Player stated that staff should have seen Resident A to give him his morning medications by 9:00am at the latest. Manager Player reported that this was the first time Resident A had eloped off the property.

On 1/22/24, a phone call was made to Resident A's case manager, Angela Carter. Case Manager Carter stated that Resident A has been able to get out of his window at this home prior to this elopement on 12/6/23. Case Manager Carter stated that he went and knocked on the home's front door and never actually eloped off the property. Case Manager Cater confirmed that there is nothing currently in Resident A's IPOS regarding the need of enhanced supervision or plans regarding preventing elopements, but that

she is working with Resident A's psychologist to get something like this added to his IPOS. Case Manager Cater stated that Resident A is very active and will get agitated when staff are checking on him often. She stated that it would be unusual not to hear something from Resident A when staff are knocking on his door multiple times. She reported that they are currently looking to move Resident A to another home within this same company where supervision will be easier.

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:	It was confirmed that Resident A was able to climb out of his bedroom window sometime before 8:00am on 12/6/23 and was found by police approximately 7 miles from the home. The last time that staff had seen Resident A was when 3rd shift staff saw him standing in his bedroom at 5:30am. Resident A's assessment plan and IPOS both state that Resident A requires staff supervision while out in the community. Resident A has been able to get out his bedroom window on at least one occasion, without staff knowing, prior to this elopement on 12/6/23. Resident A was able to push some bedroom furnishment in front of his bedroom door, put 7 layers of clothing on and climb out his window without staff knowing. Staff had not had eyes on Resident A for more than 5 hours and Resident A was away from the home for approximately 3 hours or more before staff realized that he was missing. There was more than sufficient evidence found to warrant violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 12/13/23, recipient rights investigator, Michelle Salem, stated that as part of her investigation that she looked at this home's medication administration record (MAR). She stated that Resident A's MAR shows that staff person, Delaina Sanders, initialed indicating that she gave Resident A his 8:00am medications on 12/6/23.

On 12/14/23, an on-site inspection was conducted, and Resident A's MAR was reviewed. The MAR confirms that Staff Sanders initialed the MAR on 12/6/23, indicating that she gave Resident A all his nine 8:00am medications. The MAR states that all nine medications were to either be passed in the morning or twice daily. The number of pills left in Resident A's bubble packs appeared to be accurate and consistent with the morning medications being passed on 12/6/23.

On 12/14/23, Staff Sanders stated that she did not have contact with Resident A the morning of 12/6/23, before 11:00 am when she realized that he had eloped from the home. She stated that she gave Resident A his 8:00am medications when Resident A returned to the home from hospital. Staff Sanders claims that she does not remember what time she actually gave Resident A his medications, just that it was after 12:00pm. She claims that administrator, Sharon Butler, told her she could pass the medications at that time.

On 12/14/23, Admin Butler denied that she gave Staff Sanders permission to give Resident A his 8:00am medications that afternoon. Admin Butler stated that she did not return to the home with Resident A on 12/6/23 until at least 2:30pm, which is way past the time limit in which the 8:00am medications could be passed.

On 1/22/24, home manager, Shantel Player, stated that all medications that are written to be passed twice daily are passed at 8:00am and 8:00pm. She stated that staff are allowed to pass medications within one hour before and one hour after those times, so morning medications should not have been passed after 9:00am.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Staff person, Delaina Sanders, admits that she gave Resident A his morning medications on 12/6/23, but did not do so until he returned home from the hospital. Staff Sanders stated that she did not have contact with Resident A during the morning on 12/6/23 and did not see him until he returned from the hospital.

	Resident A’s MAR shows Staff Sanders initials for all nine morning medications on 12/6/23. The MAR states that all nine medications were to either be passed in the morning or twice daily. The number of pills left in Resident A’s bubble packs appeared to be accurate and consistent with the morning medications being passed on 12/6/23. Administrator, Sharon Butler, stated that she did not return to the home from the hospital with Resident A until at least 2:30pm. There was sufficient evidence found to support this rule violation, as Resident A’s morning medications were not passed pursuant to label instructions.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 1/22/24, an exit conference was held with licensee designee, Paula Barnes. She was informed of the outcome of this investigation and that a corrective action plan is required.

IV. RECOMMENDATION

Upon receipt of an approved written corrective action plan, it is recommended that the status of this home’s license remain unchanged.

Christopher A. Holvey

1/23/2024

Christopher Holvey Date
Licensing Consultant

Approved By:

Mary Holton

1/23/2024

Mary E. Holton Date
Area Manager