GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 16, 2024

Roger Covill
North-Oakland Residential Services Inc
P. O. Box 216
Oxford, MI 48371

RE: License #: AS630339744
Edgar Home
8740 Andersonville Road
Clarkston, MI 48347

Dear Roger Covill:

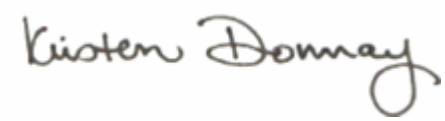
Attached is the Renewal Licensing Study Report for the facility referenced above. The violations cited in the report require the submission of a written corrective action plan. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific dates 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 licensee or licensee designee and a date.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan within 15 days.

Please contact me with any questions. In the event that I am not available and you need to speak to someone immediately, you may contact the local office at (248) 975-5053.

Sincerely,



Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
(248) 296-2783

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
RENEWAL INSPECTION REPORT

I. IDENTIFYING INFORMATION

License #:	AS630339744
Licensee Name:	North-Oakland Residential Services Inc
Licensee Address:	106 S. Washington Oxford, MI 48371
Licensee Telephone #:	(248) 969-2392
Licensee Designee:	Roger Covill
Name of Facility:	Edgar Home
Facility Address:	8740 Andersonville Road Clarkston, MI 48347
Facility Telephone #:	(248) 625-4273
Original Issuance Date:	06/13/2013
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. METHODS OF INSPECTION

Date of On-site Inspection(s): 03/07/2024

Date of Bureau of Fire Services Inspection if applicable: N/A

Date of Environmental/Health Inspection if applicable: 11/07/2023

No. of staff interviewed and/or observed 3
No. of residents interviewed and/or observed 6
No. of others interviewed 2 Role: Area Manager/Lic. Desig.

- Medication pass / simulated pass observed? Yes ☒ No ☐ If no, explain.
- Medication(s) and medication record(s) reviewed? Yes ☒ No ☐ If no, explain.
- Resident funds and associated documents reviewed for at least one resident? Yes ☒ No ☐ If no, explain.
- Meal preparation / service observed? Yes ☒ No ☐ If no, explain.
- Fire drills reviewed? Yes ☒ No ☐ If no, explain.
- Fire safety equipment and practices observed? Yes ☒ No ☐ If no, explain.
- E-scores reviewed? (Special Certification Only) Yes ☒ No ☐ N/A ☐ If no, explain.
- Water temperatures checked? Yes ☐ No ☐ If no, explain.
- Incident report follow-up? Yes ☒ No ☐ If no, explain.
- Corrective action plan compliance verified? Yes ☒ CAP date/s and rule/s: N/A ☐
- Number of excluded employees followed-up? N/A ☒
- Variances? Yes ☐ (please explain) No ☐ N/A ☒

III. DESCRIPTION OF FINDINGS & CONCLUSIONS

This facility was found to be in non-compliance with the following rules:

R 330.1803	**Facility environment; fire safety.**
	(1) A facility that has a capacity of 4 to 6 clients shall be equipped with an interconnected multistation smoke detection system which is powered by the household electrical service and which, when activated, initiates an alarm that is audible in all areas of the home. The smoke detection system shall be installed on all levels, including basements, common activity areas, and outside each sleeping area, but excluding crawl spaces and unfinished attics, so as to provide full coverage of the home. The system shall include a battery backup to assure that the system is operable if there is an electrical power failure and accommodate the sensory impairments of clients living in the facility, if needed. A fire safety system shall be installed in accordance with the manufacturer's instructions by a licensed electrical contractor and inspected annually. A record of the inspections shall be maintained at the facility.

The facility's smoke detection system was not inspected annually in 2023. Inspections were completed in September 2022 and February 2024.

R 400.14306	**Use of assistive devices.**
	(3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the authorization.

During the onsite inspection, there were no authorizations on file for Resident A's therapeutic supports, including his gait belt, leg braces, and wheelchair for long distances.

R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

During the onsite inspection, I reviewed Resident A, Resident B, and Resident C's medications and medication administration records (MARs). I noted the following:

- Resident A was prescribed Ketoconazole 2% shampoo- Apply 1 application topically to the affected area 2 times per week. Staff initialed the MAR indicating that the shampoo was applied more than twice a week. The MAR was initialed five times for the week of 02/04/24-02/10/24, three times for the

week of 02/11/24-02/17/24, four times for the week of 02/18/24-02/24/24, and five times for the week of 02/25/24-02/29/24.

- Resident A was prescribed Triamcinolone 0.1% cream- Apply 1 application topically to the affected area 2 times per week. Staff initialed the MAR indicating the cream was applied more than twice a week. The MAR was initialed seven times for the week of 02/04/24-02/10/24, five times for the week of 02/11/24-02/17/24, seven times for the week of 02/18/24-02/24/24, and six times for the week of 02/25/24-02/29/24.
- Resident A's Citalopram 40mg Tab- take one table by mouth daily was still in the bubble pack for the 8:00am dose on 03/05/24. The bubble pack had a start date of 03/01/24 written on it.
- Resident B's 6:00am dose of Divalproex 500mg ER Tab- Take 2 tablets by mouth in the morning and take 1 tablet in the evening was still in the bubble pack for 03/01/24 and 03/06/24. There was no start date written on the bubble pack.
- Resident B's 8:00pm dose of Hydroxyzine HCL 10mg tab- Take 1 tablet by mouth at bedtime was still in the bubble pack for 03/01/24. There was no start date written on the bubble pack.
- Resident B's November 2023 MAR notes that he did not receive his 6:00am dose of Olanzapine 15mg on 11/02/23 because the medication was not refilled and was not available in the home.
- Resident B's February 2024 MAR notes that he did not receive his 6:00am dose of Clozapine 200mg because the medication was not in the home.
- Resident B's February 2024 MAR notes that he did not receive his Lorazepam 0.5mg tab- Take 1 tablet by mouth in the morning and at bedtime and take 2 tablets every afternoon from 02/27-02/29/24 because the medication was not available in the home.
- Resident C was prescribed Prednisone 20mg tablet- Take 1 tablet by oral route for 5 days and Benzonatate 100mg capsule- Take 1 capsule 3 times a day by oral route for 5 days on 02/27/24. These medications were not listed on Resident C's February or March medication administration records. It is unknown if he received the medications as prescribed.

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.

During the onsite inspection, I reviewed Resident A, Resident B, and Resident C's medications and medication administration records. I noted the following:

- The label instructions for Resident A's Triamcinolone 0.1% cream did not match the instructions on the MAR or prescription. The MAR and prescription stated- Triamcinolone 0.1% Apply 1 application topically to the affected area *2 times per week*. The label states Nystatin/Triamcin 100000 Unit/1MG/GM TO cream- Apply 1 application topically to affected area *2 times per day*.
- Resident A is prescribed Vitamin D2 50,000U Cap- Take 1 capsule by mouth every week (Saturdays). Staff initialed the MAR from Sunday, 02/04/24, through Wednesday, 02/07/24, but then crossed out the initials.
- Resident A's February 2024 MAR had written in Prednisone 20mg tablet- Take 1 tablet by mouth daily for 5 days and Benzonatate 100mg capsule- Take 1 capsule by mouth 3 times a day for 5 days beginning 02/28/24. The MAR was initialed on 02/28/24 and 02/29/24, but both medications were crossed out without any explanation written on the MAR. During the onsite inspection, staff stated that these medications were prescribed to Resident C not Resident A. Staff stated that she wrote the medications on the wrong resident's MAR. The area manager obtained a copy of the prescriptions and confirmed they were prescribed to Resident C. The medications were not listed on Resident C's February or March 2024 medication administration records.
- Resident B's November 2023 MAR was not initialed for the 8:00pm dose of Clozapine 200mg ODT Tab on 11/03/23.
- Resident B's March 2024 MAR was handwritten on a blank MAR sheet. It did not have his name or the month written on it.
- Staff were not using a consistent method to document when Resident B did not receive his Lorazepam, Clozapine, or Olanzapine due to the medications not being available in the home. Some staff circled their initials on the MAR, others put an X in the box, some staff initialed and made a note on the back of the MAR, and some staff initialed the MAR with no indication that the medication was not given.
- On 03/06/24, Resident B's Lorazepam 0.5mg Tab- take 1 tablet by mouth in the morning and at bedtime and take 2 tablets every afternoon was discontinued. Staff initialed the MAR at 4:00pm and 8:00pm on 03/06/24 but crossed out their initials. Staff initialed the MAR at 8:00am on 03/07/24. The area manager stated there were issues getting this prescription refilled and she did not believe it was passed at all in March, but staff initialed the MAR from 03/01/24-03/06/24.
- On 03/06/24, Resident B's prescription for Divalproex 500mg ER Tab was changed from Take 2 tablets by mouth in the morning to Take 2 tablets by

mouth in the morning and 1 tablet in the evening. The home manager indicated on the MAR that the prescription was discontinued by Dr. Long on 03/06/24, but she did not write in the new prescription. As such, staff did not initial the MAR or pass the morning dose on 03/07/24.

- Resident C's March 2024 MAR was not initialed for the 8:00am dose of Omeprazole 40mg CAP on 03/07/24.

Staff were not following proper medication training protocol by checking the 5 rights of medication passing and did not follow the proper documentation procedures for missed medications.

REPEAT VIOLATION ESTABLISHED
Reference Renewal Licensing Study Report dated 03/10/2022; CAP dated 03/09/2022

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: (f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.

During the onsite inspection, the area manager indicated that there were issues getting Resident B's psychotropic medications refilled. Resident B missed several doses of his Lorazepam, Clozapine, and Olanzapine. There was no documentation on file to reflect the efforts that were made to obtain the medications, contacts with a health care professional, or the instructions that were given regarding the missed medications.

REPEAT VIOLATION ESTABLISHED
Reference Renewal Licensing Study Report dated 03/10/2022; CAP dated 03/09/2022

R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.

On 02/27/24, Resident C was prescribed Prednisone 20mg tablet- Take 1 tablet by mouth daily for 5 days and Benzonatate 100mg capsule- Take 1 capsule by mouth 3 times a day for 5 days beginning 02/28/24. However, staff transcribed the medications onto Resident A's February 2024 MAR instead of Resident C's MAR. The medications were initialed for two days on Resident A's MAR and then crossed out. They were never listed on Resident C's February or March medication administration records. It is unknown if the medications were given to the correct resident, as there was no documentation indicating that the error was discovered or how it was resolved.

R 400.14315	**Handling of resident funds and valuables.**
	(6) Except for bank accounts, a licensee shall not accept resident funds of more than $200.00 for any resident of the home after receiving payment of charges owed.

Resident B's Funds Part II forms showed he had more than $200 in cash on hand from January-April 2023 and September-November 2023. Resident B had $302.75 on 01/01/23 and $224.27 on 02/01/23. He had a balance of $219.29 from the end of February 2023-April 2023. He had $273.69 from September-November 2023.

R 400.14315	**Handling of resident funds and valuables.**
	(8) All resident fund transactions shall require the signature of the resident or the resident's designated representative and the licensee or prior written approval from the resident or the resident's designated representative.

Resident B's Resident Care Agreement indicates that expenses of more than $100 require written approval from his designated representative. Resident B's Funds Part II form shows that a purchase was made in the amount of $125.16 at Walmart on 05/31/23. There was no written approval on file for this transaction.

R 400.14316	**Resident records.**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: (d) Health care information, including all of the following: (iii) Statements and instructions for supervising prescribed medication, including dietary supplements and individual special medical procedures. (iv) A record of physician contacts.

During the onsite inspection, Resident C's file did not contain an appointment record documenting his physician contact following his medical appointment on 02/27/24. The area manager and staff stated that he went to the doctor for RSV (respiratory syncytial virus) and was prescribed Prednisone and Benzonatate. There was no documentation of the appointment or the prescriptions on file. The area manager obtained copies of the prescriptions from the pharmacy during the onsite inspection.

R 400.14401	**Environmental health.**
	(2) Hot and cold running water that is under pressure shall be provided. A licensee shall maintain the hot water temperature for a resident's use at a range of 105 degrees Fahrenheit to 120 degrees Fahrenheit at the faucet.

During the onsite inspection, the water temperature was measured at 124°F in the bathroom and 122°F in the kitchen.

R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.

During the onsite inspection:

- The wooden doorframes throughout the facility were splintered and damaged.
- There was a cabinet in the kitchen that was missing a door.
- The outside doorframe on the means of egress to the back patio was cracked and damaged.
- The paint was worn off the front railing.
- The furniture on the front patio was showing signs of excessive wear and tear.
- The wood on the basement stairs was cracked and splintered.

REPEAT VIOLATION ESTABLISHED
Reference Renewal Licensing Study Report dated 03/10/2022; CAP dated 03/09/2022

R 400.14403	**Maintenance of premises.**
	(5) Floors, walls, and ceilings shall be finished so as to be easily cleanable and shall be kept clean and in good repair.

During the onsite inspection:

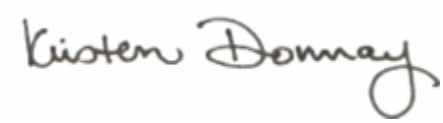
- The walls throughout the facility were scuffed and damaged.
- The walls in bedroom #2 had been colored on.

- There were cracks in the ceiling throughout the home from the house settling, where the walls meet the ceiling, including in the bathroom, bedrooms, and living room area.

I conducted an exit conference with the licensee designee, Roger Covill, in person during the onsite inspection on 03/07/24. Mr. Covill stated that he would submit a corrective action plan to address the violations identified during the inspection, and he would not contest the issuance of a provisional license.

IV. RECOMMENDATION

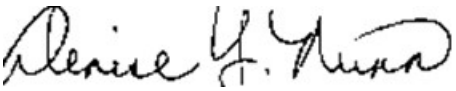
Contingent upon receipt of an acceptable corrective action plan, issuance of a provisional license is recommended.



03/11/2024

Kristen Donnay Date
Licensing Consultant

Approved by:



04/16/2024

Denise Y. Nunn Date
Area Manager