RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

February 2, 2018

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

RE: License #: AS730298050
Investigation #: 2018A0576011
Geddes Home

Dear Mrs. 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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 (810) 787-7031.

Sincerely,

Christina Garza, Licensing Consultant
Bureau of Community and Health Systems
4809 Clio Road
Flint, MI 48504
(810) 240-2478

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS730298050
Investigation #:	2018A0576011
Complaint Receipt Date:	12/07/2017
Investigation Initiation Date:	12/07/2017
Report Due Date:	02/05/2018
Licensee Name:	Central State Community Services, Inc.
Licensee Address:	Suite 201 2603 W Wackerly Rd., Midland, MI 48640
Licensee Telephone #:	(989) 631-6691
Administrator:	Paula Ott
Licensee Designee:	Paula Ott
Name of Facility:	Geddes Home
Facility Address:	7741 Geddes Road, Saginaw, MI 48609
Facility Telephone #:	(989) 781-3419
Original Issuance Date:	12/15/2008
License Status:	REGULAR
Effective Date:	06/29/2017
Expiration Date:	06/28/2019
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
A resident was not secured in her wheelchair in the van, resulting in her falling out of the chair. Resident suffered two broken femurs as a result.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/07/2017	Special Investigation Intake 2018A0576011
12/07/2017	Contact - Document Received Incident Reports received regarding Resident A
12/07/2017	Special Investigation Initiated - Letter Email sent to Anthony Navarre, Saginaw County Office of Recipient Rights (ORR)
12/07/2018	Contact - Document Received Email received from Anthony Navarre
12/08/2017	Contact - Telephone call made Phone interview of Staff, Dominque Griffin and Jennifer Valeck
12/08/2017	Contact - Telephone call made Spoke to Anthony Navarre
12/16/2017	Contact - Document Received Incident Report received
12/18/2017	APS Referral APS Referral made
01/12/2018	Contact - Telephone call made Left message for Janet Marchinol, Covenant Hospital Social Worker
01/12/2018	Contact - Document Sent Email sent to Anthony Navarre
01/12/2018	Contact - Telephone call made

	Spoke to Kelly Wright, Hometown Hospice Nurse
01/12/2018	Contact - Telephone call made Left message for Kirsten Roberts, Northview Nurse Practitioner
01/12/2018	Contact - Telephone call made Spoke to Victoria Bennett, Clerk Saginaw County Medical Examiner Office
01/12/2018	Contact - Document Sent Email sent to Dr. Russell Bush, Saginaw County Medical Examiner
01/16/2018	Contact - Document Received Email received from Anthony Navarre
01/16/2018	Contact - Telephone call received Spoke to Deb Tubb, Program Manager Saginaw County Medical Examiner Office
01/17/2018	Contact - Telephone call received Spoke to Kirsten Roberts
01/26/2018	Inspection Completed On-site Spoke with Home Manager, Mary Fowler
02/01/2018	Contact - Telephone call made Spoke to Mary Fowler
02/01/2018	Contact - Document Received Reviewed Resident A's Health Care Appraisal
02/01/2018	Contact - Telephone call made Spoke to Deb Tubb
02/01/2018	Contact - Document Sent Email sent to Deb Tub
02/02/2018	Contact - Telephone call made Spoke to Mary Fowler
02/02/2018	Contact - Document Received Reviewed Resident A's Assessment Plan and IPOS
02/02/2018	Contact - Telephone call made Left message for Resident A's Guardian to return call

02/02/2018	Exit Conference Exit conference conducted with Licensee Designee, Paula Ott

ALLEGATION:

A resident was not secured in her wheelchair in the van, resulting in her falling out of the chair. Resident suffered two broken femurs as a result.

INVESTIGATION:

On December 7, 2017, I received an *Incident / Accident Report (IR)* from Geddes Home authored by Jennifer Valeck. The report included three separate staff statements from Dominique Griffin, Jennifer Valeck and Sandra Slabinski. The IR indicated that "staff were driving down the road and stopped at light. Resident A's tray fell off and she fell out of her chair. Staff lifted her back in chair, brought her in house and went to check to make sure she was ok and noticed as soon as taking her pants off her knees were swollen. Called 911 right away. When EMT arrived they suspected broken femur on both legs which they said with her brittle bones could be the reason why they broke so easily. If they are broke." Corrective measure indicated Resident A "is in the process of getting a new wheelchair that is safer for her transporting as well as her physical needs". "Physician's Diagnosis of Injury, Illness or Cause of Death, If known" listed "Femur fracture-both legs/C-6".

Staff, Jennifer Valeck's written statement indicated the following: "I was going down State St and stopped at the red light on River Rd. While I was stopping Resident A's tray fell off which she leans forward on so when her tray fell off she fell out of her chair. Then the other staff climbed back there with Resident A to make sure she was ok and didn't move anymore, and stayed with her until arriving back home because there was nowhere to pull over and we were right down the street from home. After arriving home both staff lifted her up in her chair and brought her in and got her undressed right away to make sure she wasn't hurt. While taking her pants off we notice her knees were really swollen right after called 911 right away."

Staff, Dominique Griffin's statement indicated the following: "I and another staff took Resident A and another consumer to the movies. Resident A had all belts on and strapped down, break lock and tray on made it to the movies with no problem. On the way back Resident A had all belts on and strapped down, break locked and tray on as well. We got on State I noticed that it was traffic I told the staff that was driving to slow down more than once she slowed down Resident A fell out her wheelchair I jumped in the back with her to make sure she was ok. She could not stop the van cars behind us. We got her home got her in her wheelchair. Got in her bed started check her over. Noticed she was in pain called home manager then called 911."

Staff, Sandra Slabinski's statement indicated the following: "Staff arrived at Covenant Hospital at around 5:30pm. Was directed to a private waiting from around 6pm. Hospital staff came into confirm contact numbers for Resident A. Staff was finally

allowed to see Resident A for a few minutes at around 7:45pm. Staff was informed she was on 2nd order of blood transfusion and doctor had ordered another round. She was in hospital bed in partial (back of legs) casts wrapped w/ace bandages. She was given multiple X-rays and CAT scans. Nurses asked staff to spend most of time in 2 separate waiting rooms. Resident A was covered with warming blanket to raise temp back to normal range. Resident A was also sedated a few times. They said the biggest worry was very low blood pressure, low body temp and risk of hypothermia. Resident A was alert during times when staff was able to be in the room. Resident A asked staff her normal requests. 'Up, book, room, cartoons.' She also told staff she was going to be a 'good girl'. Resident A was hooked up to weights to realign her femurs. She is in Covenant ICU. Resident A requested to go home as staff was leaving. Staff returned to Geddes home around 2:55am."

On December 7, 2017, I email Anthony Navarre, Saginaw County Office of Recipient Rights (ORR) regarding accident involving Resident A. Mr. Navarre and I exchanged emails and discussed interviews of staff involved in the accident.

On December 8, 2017, I completed a phone interview with Dominique Griffin, Direct Care Staff from Geddes Home. Ms. Griffin was at the office of Anthony Navarre from the Saginaw County Office of Recipient Rights (ORR) and Mr. Navarre was also asking questions of Ms. Griffin. Ms. Griffin reported she has been employed at Geddes Home for over one year. Ms. Griffin was asked about Resident A's diagnosis and confirmed she was aware of Resident A's diagnosis, which included scoliosis and brittle bone disease. With regards to the accident, Ms. Griffin reported they were on their way home from the movies and Ms. Griffin reported she was the staff person who strapped Resident A in the van. Ms. Griffin reported her coworker was driving, made a sudden stop, and Resident A came out of her wheelchair. Ms. Griffin reported when this happened she hopped in the back and got on the floor with Resident A. Ms. Griffin reported Resident A's wheelchair had not moved when Resident A came out of the chair. Ms. Griffin reported she tried to soothe Resident A because she knew Resident A was in pain as Resident A screamed. Ms. Griffin advised that Resident A did not have a seat belt on her wheelchair. Ms. Griffin reported Resident A had a tray on her wheelchair and this is what she used to secure Resident A to her wheelchair. Ms. Griffin confirmed there is a shoulder harness in the van that is to be used to fasten the residents but this was not used. Ms. Griffin reported she has never used the harness to secure residents in the wheelchairs and only used the tie downs to secure the wheelchair to the van. Ms. Griffin reported that after the accident they took Resident A home and checked her over and saw bruises on her legs. At that time, 911 was contacted. Ms. Griffin was asked to explain how she prepares a resident who uses a wheelchair for transit. Ms. Griffin reported she uses the lift to get them in the van and there are tie downs and straps to secure the wheelchair to the van. Ms. Griffin was asked if she received proper training with respect to transporting residents who use wheelchairs and how to properly secure them in the van and she reported she does not believe she was properly trained.

On December 8, 2017, I completed a phone interview with Jennifer Valeck, Direct Care Staff from Geddes Home. Ms. Valeck was at the office of Anthony Navarre from the Saginaw County Office of Recipient Rights (ORR) and Mr. Navarre was also asking questions of Ms. Valeck. Ms. Valeck reported being employed at Geddes Home for over one year. Regarding Resident A, Ms. Valeck reported she was aware Resident A had scoliosis and brittle bone disease. With respect to the accident, Ms. Valeck reported they left the movies and her coworker, Dominque Griffin strapped Resident A in the van. Ms. Valeck was driving and she stopped. Resident A's tray came off of her wheelchair and Resident A fell out of her chair. Ms. Valeck reported the tray on Resident A's wheelchair was used to keep her in place during transports. When Resident A fell out of her wheelchair, Ms. Griffin told her she fell and went to the back with Resident A. Ms. Valeck reported there was nowhere for her to turn around so she made the decision to continue the drive and return to the facility. Mr. Navarre advised Ms. Valeck that there was a place she could have stopped and Ms. Valeck reported they were close to the facility and she did not think about if it was safe to take Resident A home and move her. Ms. Valeck reported when they arrived to the home, she and Ms. Griffin grabbed Resident A's pants and arms to lift her up and get her into the home. Ms. Valeck reported she was "not really" trained on how to secure residents who use wheelchairs in the van. Regarding Resident A being transported in the van, Ms. Valeck reported staff were to use tie downs on the four corners of the wheelchair and to ensure Resident A has her tray on her wheelchair so she would not fall out of the chair. Ms. Valeck reported there is no way to use the van seat belt on Resident A as the tray is in the way. Ms. Valeck reported she told Home Manager, Mary Fowler that Resident A needed a seat belt and Ms. Fowler was supposed to order one. Ms. Valeck reported no staff know how to properly secure residents in the van and she needs training in this area.

On December 8, 2017, I spoke with Anthony Navarre. Mr. Navarre reported Resident A is "in a lot of danger at the hospital". Resident A has had surgery on her legs. Mr. Navarre reported there may be check off list for staff with respect to training for van safety, lift and tie downs that are included in the new hire orientation. Mr. Navarre reported that Resident A is to be secured down while in transit per her Individual Plan of Service (IPOS). On January 12, 2018, I sent an email to Mr. Navarre regarding any updates he can provide. On January 16, 2017, Mr. Navarre emailed and reported that the two staff involved in the accident have been terminated from employment at Geddes Home, per the Home Manager, Mary Fowler. Mr. Navarre reported he has not yet completed his report but he expects to "substantiate Neglect 1 due to the staff/home not properly strapping the recipient in the van and another Neglect 1 for the staff/home not calling 9-1-1 immediately and instead driving the recipient home and moving her from the van floor to the wheelchair to the bed".

On December 16, 2017, I received a second IR authored by the Home Manager, Mary Fowler. The IR indicated the following: "On 12-15-17, Northview was here to do follow-up visit with Resident A, and wanted to talk to the guardian about hospice service, Guardian came and decision was made to put Resident A on hospice. At time of admission, it was estimated she would survive about 1 week, by the end of the evening

it was estimated less than 24 hours. Resident A passed away at 9:17am on 12/16/17. Staff stayed with her and comforted her until guardian arrived.

On December 18, 2017, I made a referral to Adult Protective Services (APS). I was advised I would be notified in writing if the complaint was assigned for investigation.

On January 12, 2018, I left a message for Covenant Hospital Social Worker, Janet Marchinol to return my call. I also emailed Anthony Navarre, ORR requesting any updates he can provide.

On January 12, 2018, I spoke to Hometown Hospice Nurse, Kelly Wright who reported she provided hospice services to Resident A for one day. Ms. Wright advised she did not know Resident A prior to her accident and Ms. Wright only saw Resident A on Friday, December 15, 2018, and Resident A subsequently passed away on Saturday, December 16, 2017. Ms. Wright advised that when there is a major bone break, which Resident A had two, one's life span is shortened if that person has a chronic illness or elderly. Ms. Wright advised that Resident A's accident was very traumatic.

On January 12, 2018, I left a message for Kirsten Roberts, Nurse Practitioner from Northview Medical Housecalls to return my call. On January 17, 2018, I spoke to Ms. Roberts who reported Resident A was a patient of hers although a fairly new patient. Ms. Roberts reported she saw Resident A once for "routine management" prior to Resident A's accident and also saw Resident A at the home the day prior to Resident A passing away. Ms. Roberts reported Resident A's health diagnoses included high blood pressure, scoliosis, generalized arthritis, right heart failure, osteoporosis, intellectual disability, and compression fractures in the lower spine not due to the accident. Ms. Roberts reported Resident A was at high risk for fractures given her osteoporosis diagnosis.

On January 12, 2018, I spoke to Victoria Bennett, Clerk at the Saginaw County Medical Examiner Office. Ms. Bennett advised that Resident A's cause of death were as follows: A) Acute Congestive Heart Failure; B) Blood Loss, Anemia and Shock with Blood Replacement; C) Blunt Traumatic Femur Fractures with Surgical Repair; D) Blunt Force Trauma to Bilateral Legs. Manner of death was listed at Accident due to injury on December 6, 2017, with a fall to the knees in van accident. Ms. Bennett advised that no autopsy was done and Dr. Russell Bush, Medical Examiner reviewed Resident A's medical records in order to determine cause and manner of death and to write the death certificate.

On January 12, 2018, I sent an email to Dr. Russell Bush to inquire if I was able to speak to him regarding Resident A. On January 16, 2018, I received a call from Deb Tubb, Program Manager at the Saginaw County Medical Examiner Office who reported she was calling for Dr. Bush regarding my inquiry about Resident A. Ms. Tubb was asked if Resident A died due to the accident she was involved in and Ms. Tubb advised that Resident A's "death was all related to the injury from the accident". Ms. Tubb consulted with Dr. Bush and called me back and reported Resident A's death was from

blood loss, anemia, and shock and it was all related. There was fluid around the heart causing the heart to pump inefficiently and the heart began to fail because it was not working properly. This was all due to the trauma to the legs, blood loss, and trauma from fractures. On February 1, 2018, I called Ms. Tubb to request a copy of Resident A's death certificate. Ms. Tubb requested I send her an email with my request, which was completed.

On January 26, 2017, I completed an unannounced on-site inspection at Geddes Home. I interviewed the Home Manager, Mary Fowler who confirmed the two staff involved in Resident A's accident have been terminated from employment. Ms. Fowler advised that Resident A had several ailments including severe scoliosis, congestive heart failure, osteoporosis, and severe mental retardation. Resident A could not walk and had not walked in eight years. Ms. Fowler advised Resident A was not too verbal and had started to point over the last year. I asked Ms. Fowler if staff were aware of Resident A's medical conditions and she confirmed they were as they have plan of service reviews a few times a year. Ms. Fowler was asked about staff training with respect to properly securing residents in vehicles while being transported. Ms. Fowler reported staff are trained in the van lift, securing the wheelchair to the van, and securing the resident into the chair using seat belts in the van during orientation when they are hired. I requested Ms. Fowler provide me an example of a staff orientation check list that would indicate such training and one was provided. *The Central State Community Services, Inc. IN-HOUSE TRAINING CHECKLIST* for Staff Latricia Miller was reviewed. Several items were identified as being trained including "Van In-Service Including Van Lift & Tie Downs".

On January 26, 2017, Ms. Fowler was asked if safety belt training was included in this piece of training and she stated it was although it is not identified on the checklist. Ms. Fowler was asked if she believed the two staff involved in Resident A's accident were properly trained in securing residents during transit and she confirmed she believes they were properly trained. Ms. Fowler was asked what she thinks happened as to why Resident A was not secured on the day of the accident and Ms. Fowler reported she believed the staff may have been in a hurry and that is why they did not secure Resident A properly. Ms. Fowler denied being aware of staff not utilizing the seat belts to secure residents in their chairs while in transit. Ms. Fowler denied staff told her they needed additional training with respect to securing residents in the van during transports. I requested to see the van and photos were taken. There were seat belts in the rear of the van that are to be used to secure residents that utilize wheelchairs. Ms. Fowler reported Resident A did not have a seat belt on her wheelchair but did have a tray that attached to the chair so she could rest her elbows. Ms. Fowler reported the tray was not supposed to be a safety device but something to "balance her out" given her tendency to sit forward due to her diagnosis of scoliosis. Ms. Fowler reported Resident A had fallen out of her wheelchair twice before about two years ago so the tray was purchased for Resident A. The decision was made not to utilize a seat belt because there was concern that the wheelchair would topple over Resident A if she fell again. Ms. Fowler advised Resident A had her tray on her wheelchair on the day of the accident. I requested Resident A's *Health Care Appraisal, AFC Assessment Plan,* and

her *Individual Plan of Services (IPOS)*. Ms. Fowler reported she would get them from the main office and forward them to my attention.

On February 1, I called Ms. Fowler requesting Resident A *Assessment Plan, IPOS,* and *Health Care Appraisal*. Ms. Fowler reported she had Resident A's *Health Care Appraisal* and would fax to me. Ms. Fowler reported she does not yet have the *Assessment Plan* or *IPOS* but would make efforts to obtain today and forward to my attention.

On February 1, 2018, I reviewed Resident A's *Health Care Appraisal* dated for September 27, 2017, and authored by Nurse Practitioner, Cherie Smith. "Diagnosis" indicated "see attached". "General Appearance" indicated "frail, appropriate for diagnoses". "Explanation of Abnormalities/Treatment Ordered" indicated "mid right spine scoliosis, discoloration and decreased strength in all extremities".

On February 2, 2018, I spoke to Mary Fowler regarding Resident A's *AFC Assessment Plan* and *IPOS,* which was received via email. I reviewed Resident A's *IPOS*, which indicates Resident A has severe Dextroscoliosis affecting her lung capacity, breathing, and ambulation. Resident A also has severe Osteoporosis of the right knee and her spine is severely curved. The *IPOS* also reveals Resident A has a history of seizures. With regards to transportation, Resident A's *IPOS* indicates "staff will make sure that Resident A uses a seat belt properly at all times when in the vehicle".

On February 2, 2018, I attempted to call Resident A's Guardian, Guardian 1. The call was unsuccessful and a message was left for Guardian 1 to return my call.

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:	There is a preponderance of evidence to conclude Resident A was not provided supervision, protection, and personal care as defined in the act and as specified in the resident's assessment plan. On December 6, 2017, Resident A was being transported in the van by two staff from Geddes Home and neither staff ensured Resident A was properly secured during transit. Resident A was not properly secured in her wheelchair and when the van stopped, Resident A fell out of her chair resulting in two broken femurs. Resident A subsequently died on December 16, 2017, as a result of her injuries.

	Additionally, Resident A's *Individual Plan of Service (IPOS)* indicates "staff will make sure that Resident A uses a seat belt properly at all times when in the vehicle". Resident A was not secured in her wheelchair utilizing a seat belt resulting in her falling out of the chair causing injury.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On December 8, 2017, I completed a phone interview with Dominique Griffin, Direct Care Staff from Geddes Home. Ms. Griffin was the office of Anthony Navarre from the Saginaw County Office of Recipient Rights (ORR) and Mr. Navarre was also asking questions of Ms. Griffin. Ms. Griffin reported they were on their way home from the movies and Ms. Griffin reported she was the staff person who strapped Resident A in the van. Ms. Griffin reported her coworker was driving, made a sudden stop, and Resident A came out of the wheelchair. Ms. Griffin advised that Resident A did not have a seat belt on her chair. Ms. Griffin reported Resident A had a tray on her wheelchair and this is what she used to secure Resident A to her wheelchair. Ms. Griffin confirmed there is a shoulder harness in the van that is to be used to fasten the residents but this was not used. Ms. Griffin reported she has never used the harness to secure residents in the wheelchairs and only used the tie downs to secure the wheelchair to the van. Ms. Griffin was asked to explain how she prepares a resident who uses a wheelchair for transit. Ms. Griffin reported she uses the lift to get them in the van and there are tie downs and straps to secure the wheelchair to the van. Ms. Griffin was asked if she received proper training with respect to transporting residents who use wheelchairs and how to properly secure them in the van and she reported she does not believe she was properly trained.

On December 8, 2017, I completed a phone interview with Jennifer Valeck, Direct Care Staff from Geddes Home. Ms. Valeck was the office of Anthony Navarre from the Saginaw County Office of Recipient Rights (ORR) and Mr. Navarre was also asking questions of Ms. Valeck. Ms. Valeck reported they left the movies and her coworker, Dominque Griffin strapped Resident A in the van. Ms. Valeck was driving and she stopped. Resident A's tray came off of her wheelchair and Resident A fell out of her chair. Ms. Valeck reported the tray on Resident A's wheelchair was used to keep her in place during transports. Ms. Valeck reported she was "not really" trained on how to secure residents who use wheelchairs in the van. Regarding Resident A being transported in the van, Ms. Valeck reported staff were to use tie downs on the four corners of the wheelchair and to ensure Resident A has her tray on her wheelchair so she would not fall out of the chair. Ms. Valeck reported there is no way to use the van seat belt on Resident A as the tray is in the way. Ms. Valeck reported she told Home Manager, Mary Fowler that Resident A needed a seat belt and Ms. Fowler was

supposed to order one. Ms. Valeck reported no staff know how to properly secure residents in the van and she needs training in this area.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**
ANALYSIS:	There is a preponderance of evidence to conclude staff were not properly training in transporting residents who require the use of wheelchairs. On December 6, 2017, Resident A was being transported by two staff. Neither staff ensured Resident A was properly secured during transport. Resident A fell out of her wheelchair resulting in a significant injury and ultimately her death. Both staff indicate Resident A's tray is what they used to secure Resident A in her wheelchair during transports. Both staff indicate they were not properly trained on how they are to secure wheelchair residents in the vehicle during transit.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On February 2, 2018, I spoke to Mary Fowler regarding Resident A's AFC Assessment Plan and IPOS. Ms. Fowler reported Resident A's tray was something the guardian wanted and the guardian and Resident A purchased the tray from Saginaw Medical. Ms. Fowler reported there was no doctor order for tray and the tray was not indicated on Resident A's *IPOS* or *Assessment Plan*.

On February 2, 2018, I received Resident A's *AFC Assessment Plan* and *IPOS*. With respect to "Use of Assistive Devices" or "Special Equipment Used" on Resident A's *AFC Assessment Plan*, it is not documented that Resident A utilizes a tray on her wheelchair. I also reviewed Resident A's *IPOS*, which does not indicate Resident A is to utilize a tray on her wheel chair.

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(2) An assistive device shall be specified in a resident's written assessment plan and agreed upon by the resident or the resident's designated representative and the licensee.
ANALYSIS:	There is a preponderance of evidence to conclude a rule violation as Resident A's assistive device, a tray that attached to her wheelchair, was not specified in her assessment plan or IPOS upon review.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On February 2, 2018, I spoke to Mary Fowler regarding Resident A's AFC Assessment Plan and IPOS. Ms. Fowler reported Resident A's tray was something the guardian wanted and the guardian and Resident A purchased the tray from Saginaw Medical. Ms. Fowler reported there was no doctor order for tray and the tray was not indicated on Resident A's IPOS or Assessment Plan.

APPLICABLE RULE	
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.
ANALYSIS:	There is a preponderance of evidence to conclude a rule violation as Resident A's therapeutic support, a tray that attached to her wheel chair, was not authorized in writing by a licensed physician.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On December 7, 2017, I received an *Incident / Accident Report (IR)* from Geddes Home authored by Jennifer Valeck. The report included three separate staff statements from Dominique Griffin, Jennifer Valeck and Sandra Slabinski. The IR indicated that "staff were driving down the road and stopped at light. Resident A's tray fell off and she fell out of her chair. Staff lifted her back in chair, brought her in house and went to check to make sure she was ok and noticed as soon as taking her pants off her knees were swollen. Called 911 right away. When EMT arrived they suspected broken femur on both legs which they said with her brittle bones could be the reason why they broke so easily. If they are broke." Corrective measure indicated Resident A "is in the process of getting a new wheelchair that is safer for her transporting as well as her physical needs". "Physician's Diagnosis of Injury, Illness or Cause of Death, If known" listed "Femur fracture-both legs/C-6".

Staff, Jennifer Valeck's statement indicated the following: "I was going down State St and stopped at the red light on River Rd. While I was stopping Resident A's tray fell off which she leans forward on so when her tray fell off she fell out of her chair. Then the other staff climbed back there with Resident A to make sure she was ok and didn't move anymore, and stayed with her until arriving back home because there was nowhere to pull over and we were right down the street from home. After arriving home both staff lifted her up in her chair and brought her in and got her undressed right away to make sure she wasn't hurt. While taking her pants off we notice her knees were really swollen right after called 911 right away."

Staff, Dominique Griffin's statement indicated the following: "I and another staff took Resident A and another consumer to the movies. Resident A had all belts on and strapped down, break lock and tray on made it to the movies with no problem. On the way back Resident A had all belts on and strapped down, break locked and tray on as well. We got on State I noticed that it was traffic I told the staff that was driving to slow down more than once she slowed down Resident A fell out her wheelchair I jumped in the back with her to make sure she was ok. She could not stop the van cars behind us. We got her home got her in her wheelchair. Got in her bed started check her over. Noticed she was in pain called home manager then called 911."

On December 8, 2017, I completed a phone interview with Dominique Griffin, Direct Care Staff from Geddes Home. Ms. Griffin was at the office of Anthony Navarre from the Saginaw County Office of Recipient Rights (ORR) and Mr. Navarre was also asking questions of Ms. Griffin. With regards to the accident, Ms. Griffin reported they were on their way home from the movies and Ms. Griffin reported she was the staff person who strapped Resident A in the van. Ms. Griffin reported her coworker was driving, made a sudden stop, and Resident A came out of the wheelchair. Ms. Griffin reported when this happened she hopped in the back and got on the floor with Resident A. Ms. Griffin reported Resident A's wheelchair had not moved when Resident A came out of the chair. Ms. Griffin reported she tried to soothe Resident A because she knew Resident A was in pain as Resident A screamed. Ms. Griffin reported that after the accident they

took Resident A home and checked her over and saw bruises on her legs. At that time, 911 was contacted.

On December 8, 2017, I completed a phone interview with Jennifer Valeck, Direct Care Staff from Geddes Home. Ms. Valeck was the office of Anthony Navarre from the Saginaw County Office of Recipient Rights (ORR) and Mr. Navarre was also asking questions of Ms. Valeck. With respect to the accident, Ms. Valeck reported they left the movies and her coworker, Dominque Griffin strapped Resident A in the van. Ms. Valeck was driving and she stopped. Resident A's tray came off of her wheelchair and Resident A fell out of her chair. Ms. Valeck reported the tray on Resident A's wheelchair was used to keep her in place during transports. When Resident A fell out of her wheelchair, Ms. Griffin told her she fell and went to the back with Resident A. Ms. Valeck reported there was nowhere for her to turn around so she made the decision to continue the drive and return to the facility. Mr. Navarre advised Ms. Valeck that there was a place she could have stopped and Ms. Valeck reported they were close to the facility and did not think about if it was safe to take Resident A home and move her. Ms. Valeck reported when they arrived to the home, she and Ms. Griffin grabbed Resident A's pants and arms to lift her up and get her into the home.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	There is a preponderance of evidence to conclude a rule violation as Resident A was involved in an accident and staff did not seek medical care immediately. On December 6, 2017, Resident A was being transported by two staff in the facility's van. Resident A was not properly secured while in transit and fell out of her wheelchair. Staff did not call for 911 at the onset of the accident and continued home with Resident A. Staff then took Resident A out of the vehicle by lifting her up by her arms and pants. Resident A was placed in her chair, then placed in her bed, her clothes removed, and checked over by staff. Resident A was found to have injuries and it was at that time 911 was contacted.
CONCLUSION:	**VIOLATION ESTABLISHED**

On February 2, 2018, I spoke with Paula Ott, Licensee Designee for Geddes Home. I advised Ms. Ott I would be requesting a corrective action plan with respect to the rule violations. I also advised Ms. Ott that I would be recommending a provisional license.

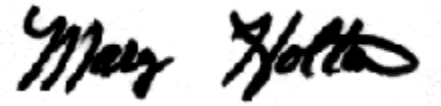
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend modification of the license to provisional.

02/02/2018

Christina Garza Date
Licensing Consultant

Approved By:



02/02/2018

Mary E Holton Date
Area Manager