GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 8, 2019

Barry Bruns
HomeLife Inc
PMB #360
5420A Beckley Rd.
Battle Creek, MI 49015

RE: License #: AM030353416
Investigation #: 2019A0350025
691 W. Bridge Street AFC

Dear Mr. Bruns:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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 contact me. In any event, the corrective action plan is due within 15 days.

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 (616) 356-0183.

Sincerely,

Ian Tschirhart, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 644-9526

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM030353416
Investigation #:	2019A0350025
Complaint Receipt Date:	03/19/2019
Investigation Initiation Date:	03/19/2019
Report Due Date:	04/18/2019
Licensee Name:	HomeLife Inc
Licensee Address:	3 Heritage Oak Lane, Battle Creek, MI 49015
Licensee Telephone #:	(269) 660-0854
Administrator:	Barry Bruns
Licensee Designee:	Barry Bruns
Name of Facility:	691 W. Bridge Street AFC
Facility Address:	691 W. Bridge Street, Plainwell, MI 49080
Facility Telephone #:	(269) 225-1021
Original Issuance Date:	02/04/2014
License Status:	REGULAR
Effective Date:	08/11/2018
Expiration Date:	08/10/2020
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED, MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was not prompted by staff to eat slowly or to eat small pieces of food as it states in his Assessment Plan. Resident A choked on a piece of meat and died the following day.	Yes

III. METHODOLOGY

03/19/2019	Special Investigation Intake 2019A0350025
03/19/2019	Special Investigation Initiated - Telephone I received a call from Scott Salmoni, Home Manager, informing me that Resident A past away
03/19/2019	Contact - Document Received I received an email from Lisa Smith, Recipient Rights Officer from Kalamazoo, informing me of meeting date, time, and place
03/19/2019	Contact - Document Sent I sent Ms. Smith an email confirming my attendance at the upcoming meeting
03/20/2019	APS Referral
03/22/2019	Contact - Face to Face Ms. Smith and I and Officer Luthy from the Plainwell Police Dept. interviewed staff members
03/27/2019	Contact - Telephone call received I spoke with Barry Bruns, Licensee Designee
03/27/2019	Contact - Document Received Mr. Bruns sent me some documents
04/04/2019	Exit Conference Held with Barry Bruns, Licensee Designee

ALLEGATION: Resident A was not prompted by staff to eat slowly or to eat small pieces of food as it states in his Assessment Plan. Resident A choked on a piece of meat and died the following day.

INVESTIGATION: On 03/18/2019, I received a telephone call from Lisa Smith, the Recipient Rights Officer for Kalamazoo Community Mental Health and Substance Abuse Services. Ms. Smith informed me that home staff may not have followed the choking protocol correctly and said she would be investigating this matter. I told her I would also investigate it.

On 03/18/2019, I received a call from Barry Bruns, Licensee Designee, informing me of this incident. Mr. Bruns stated Resident A was currently in the hospital following his choking on food on 03/16/2019.

On 03/18/2019, I received three Incident Reports (IR) pertaining to this situation. One had been completed by Erin Little, one by Amber Fries, and the third by Renata Hartman, all are Direct Care Workers (DCW).

The IR written by Erin Little with the time of 6 p.m. written on it states: *"Around 6pm, during dinner, staff RH and EL went over to (Resident A) because he was shaking and not eating. Staff tried to ask him if he was okay, but he was not responding. While RH was standing behind/next to him, EL kneeled down as MR leaned over/passed out over the side of his chair. EL noticed his face was turning purple and RH told staff AF to call 9-1-1. After figuring out that he was choking, both RH and EL attempted to use the Heimlich Maneuver on (Resident A). This was not working so staff began preparation to give (Resident A) CPR. Staff did not attempt CPR because RH found food lodged in (Resident A's) throat and used her finger to get it out. At this point (Resident A) was no longer conscious and it was unclear how long before that that he had stopped breathing. RH continued to try and get food out of (Resident A's) throat while paramedics and police arrived. They arrived within an estimated 5 minutes of AF calling. EL went into living room and outside porch to ensure the other residents were ok while paramedics/police helped (Resident A). (Resident A) left in an ambulance shortly after he started breathing [sic]."*

The IR written by Amber Fries with 6:05 p.m. written on it states: *"During dinner AF heard a resident tell staff that (Resident A) was shaking a lot. Staff EL, RH, & AF went to find (Resident A) was shaking in his chair. AF took (Resident A's) cup to get more juice in case he needed it, when she heard EL say, "His face is purple, he's not responding." AF returned to the table to find (Resident A) unresponsive and RH & EL positioning (Resident A) into a better position to begin abdominal thrusts. (Resident A's) face was purple & his body limp. AF began a stopwatch & immediately called 911 while RH & EL continued first aid on (Resident A). AF instructed RH & EL to move (Resident A) to the floor & continue compressions. AF began to redirect other residents to the living room when a police officer arrived. AF then called admin on call to notify them when EMS arrived. AF stopped the stop watch after all emergency personnel left, 44 minutes [sic]."*

The IR written by Renata Hartman with 6:10 p.m. written on it states: *"Staff RH & EL both noticed (Resident A) turning purple & once EL stated "He's not responding" staff RH started the abdominal thrusts on (Resident A). (Resident A) continued to be*

un responsive & staff EL took over after a few min. Staff AF notified EMTs who arrived shortly after. (Resident A) was placed onto the floor & continued abdominal thrusts until EMT arrived in 5 minutes of call. Both staff RH & AF contacted on-call & admin on-call of situation. Staff RH called (Resident A's) brother & tried to leave a message at interact for Wendy Newland but was unable to leave message due to full mail box & called emergency for interact but staff did not know Case Manager or team to be on. Meantime EMT was able to stabilize (Resident A) after giving epideral & on-call staff met (Resident A) at hospital [sic]."

On 03/19/2019, I received a call from Scott Salmoni informing me that Resident A had died. I asked if he knew the cause of death, and he said that information was not yet available. I requested that he send me the medical records pertaining to Resident A's death as soon as they were available, and he said he would.

On 03/19/2019, through emails, I arranged to meet Ms. Smith, at this home on 03/22/2019 at 2 p.m.

On 03/20/2019, I referred this matter to the Department of Health and Human Services Centralized Intake Unit.

On 03/22/2019, I made an onsite inspection to take part in interviews of facility staff with Lisa Smith and Officer Eric Luthy from the Plainwell Police Department. Adult Protective Services denied the complaint for investigation. The meeting started with Scott Salmoni, Home Manager, Kevin Steve, Program Manager, Tiffany Rich, Assistant Home Manager, Renata Hartman, Direct Care Worker (DCW), Lisa Smith, and me being present. Mr. Salmoni stated that the hospital would not provide any records to him pertaining to Resident A's death because the "chart was closed." He said he spoke with a nurse at the hospital about getting a cause of death report and the nurse told him she would have someone contact him. I requested that Mr. Salmoni forward that person's name and contact information to me once he is contacted, and he said he would do so. At this point, Mr. Salmoni and Ms. Rich left the room.

On 03/22/2019, Ms. Smith and I interviewed DCW Renata Hartman. Ms. Hartman stated that she has been a DCW for about 18 years and that she was the 2nd Shift Supervisor on 03/16/2019, which was the date and time period when this incident occurred. Ms. Hartman stated that in addition to herself, Amber Fries and Erin Little were also working in the home on this day and time. She reported that she had served all of the residents their dinner, which was pork chops and mashed potatoes. Ms. Hartman then said that Resident A started shaking and it appeared he was not breathing so she administered "thrusts" to him. She stated they were hard to do on him because he was in a chair. Ms. Hartman informed Ms. Smith and me that while she was tending to Resident A, Amber Fries, DCW, called 9-1-1. The 9-1-1 personnel reportedly advised staff to lay Resident A on the floor and continue to do compressions, which Ms. Hartman did, with assistance from Ms. Fries. Ms. Hartman said that Resident A did not have any dietary restrictions or special instructions

about preparing his food and he is able to cut food himself, including meat, however, staff members are supposed to prompt him to eat “small bites.” Ms. Hartman acknowledged that she did not prompt Resident A to take small bites, nor did she hear Ms. Fries or Ms. Little prompt him to do so. Ms. Hartman said that Resident A used to have a “feeding PEG”, but he hasn’t needed one since she started working there. (Note: A feeding PEG is short for Percutaneous Endoscopic Gastrostomy and is an endoscopic medical procedure in which a tube is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate, for example, because of dysphagia or sedation.) Ms. Hartman reported that immediately after Resident A was discovered to be in distress, she attempted to get the food out of Resident A’s throat with her fingers, and was able to get some out, but he still wasn’t responding. She stated that just as she was about to administer CPR on him, a team of 10 Emergency Medical Technicians arrived. Five at first, then another five, and they took over. She estimated that they arrived about four-and-a-half minutes after 9-1-1 was called. She said that they had to use forceps to get the piece of meat out of Resident A’s throat. Ms. Hartman added that she not only did the thrusts on Resident A, she rotated them with pats on the back, doing 5 thrusts then 5 pats on his back. During this time, she stated she also checked Resident A’s pulse but there wasn’t one.

On 03/22/2019, Officer Luthy stated that he responded to this emergency along with other police and paramedics and observed a first responder attempting to get the food out of Resident A’s mouth with their fingers, but that didn’t work so forceps were used. Officer Luthy said that he saw the piece of meat that was taken from Resident A’s throat and it was about the size of a dollar coin. He estimated that Resident A was unconscious for about 30 minutes by the time they got the piece of meat out.

On 03/22/2019, Ms. Smith, Officer Luthy, and I interviewed Amber Fries, DCW, who confirmed that she started working at this home in July of 2018 and that she completed all her training in August 2018. Ms. Fries said that she worked with Ms. Hartman and Ms. Little 2nd shift on 03/11/2019 and that she was washing dishes while the residents were eating dinner. She informed Ms. Smith, Officer Luthy, and me that a resident came over to her and told her that Resident A was “shaking,” and she went over to Resident A and noticed that he had a “faraway” look on his face. Ms. Fries reported that Ms. Hartman and Ms. Little were tending to Resident A, and she heard Ms. Little say, “He’s not responding.” Ms. Fries stated that Ms. Hartman and Ms. Little started doing “thrusts and back blows” on Resident A and she called 9-1-1. Ms. Fries added that she started a stopwatch from this point to keep track of how long Resident A was not breathing. Ms. Fries then got the other residents out of the kitchen and then the police arrived. Ms. Fries said that while she was talking to the 9-1-1 operator, that person advised her to have Resident A placed on the floor. She stated that she relayed that information to Ms. Hartman and Ms. Little and they laid him on the floor and continued working on him until the police arrived. Once the police arrived, they took over treating Resident A. Ms. Fries then said she called Barry Bruns, Licensee Designee, and informed him of everything that happened up

to that point. Ms. Fries reported observing that Ms. Hartman did get some food out of Resident A's mouth. She said that she also went and got a face mask just in case he started breathing. Ms. Fries acknowledged that she did not prompt Resident A to cut his food into small pieces and that she did not hear Ms. Hartman or Ms. Little tell him to either. Ms. Fries stated that she has never observed Resident A having difficulty eating before, and that there was nothing in Resident A's treatment plan that said he needed to be prompted to eat small pieces of food that she knew of.

On 03/22/2019, Ms. Smith, Officer Luthy, and I interviewed Erin Little, DCW, who reported that she has worked at this home for about a month and a half. Ms. Little said that she completed all her required training is January (2019) and that part of her training included what do to if someone is choking. She said that they were taught to rotate pats on the back with abdominal thrusts. Ms. Little informed Ms. Smith, Officer Luthy, and me that she was not aware that Resident A needed to be prompted to eat slowly and take small bites of food, and she did not prompt him to do these things the evening Resident A was choking. She said that Ms. Hartman was able to get some food out of Resident A's throat. Ms. Little reported that at one point while Resident A was choking, Resident B tried the Heimlich Maneuver on him also. Ms. Little stated that CPR was not administered because Resident A had food lodged in his throat. She added that she had never observed Resident A having a problem swallowing but had seen him eat "too quickly" before. Ms. Little said that Ms. Hartman and Ms. Fries both handled the situation with composure. She said that Resident A did not give any signs that he was having trouble breathing, such as by pounding on the table. Ms. Little reported that Resident B said to staff, "He's shaking; I think he took a really big bite of food," referring to Resident A.

Kevin Steve, Program Director, stated that staff members read residents' Treatment Plans when they first start working at the home as part of their training. Staff subsequently review them annually. He showed me a signature sheet of staff members who have reviewed Resident A's Person-Centered Plan, which was written and signed on 02/12/2016, and I observed that it was signed by Ms. Hartman on 11/26/2018, Ms. Fries on 09/18/2018, and Ms. Little on 02/23/2019. Mr. Steve also provided me with a copy of Resident A's Health Care Appraisal, dated 06/06/2018, and Assessment Plan, dated 05/16/2018. Mr. Steve stated that the Person-Centered Plan (PCP) he had for Resident A was dated 02/12/2016. He stated that the Case Manager, Wendy Newland, had not yet provided the home with the most current PCP, dated 03/23/2018.

Ms. Smith showed me a copy of Resident A's Needs Inventory for Personal Care and Community Living Supports, which is part of his PCP and was dated 03/23/2018. I observed that under the Supporting Notes section of this document, it states; "(Resident A) is on a dysphagia diet, continues to require close monitoring to ensure he is eating slow and taking small bites of food due to choking hazard. He has refused to eat in the past, required physical assistance."

Scott Salmoni confirmed what Mr. Steve had reported about staff members reviewing residents' binders, which include (PCP), Behavioral Plans, and Primary Treatment Plans.

On 03/25/2019, I reviewed Resident A's Assessment Plan, which has a completion date of 05/16/2018. Next to the box A, Eating/Feeding, it states that; "Staff should monitor for signs of chocking; staff should prompt for him to take small bites [sic]." This document was signed by Resident A and the Home Manager, Scott Salmoni, on 05/16/2018.

On 03/26/2019, I reviewed Resident A's Health Care Appraisal, which is dated 06/06/2018. The appraisal lists his diagnoses as "Schizophrenic, Undifferentiated; Anxiety Disorder NOS (Not Otherwise Specified)." It also states that Resident A had a history of "G.E.R.D. (Gastroesophageal Reflux Disease), Dysphagia, Hypotension, Anemia, 'Sea Blue Syndrome.'" I looked up dysphagia on the internet and found that it means difficulty swallowing. This document was signed by Ms. Mary Kelly, RN on 06/06/2018 and Resident A on 06/07/2019.

On 03/27/2019, I received a call from Barry Bruns, Licensee Designee. He stated that he believes some of the language in the last PCP they received from Resident A's Case Manager had been "cut and pasted", including the part about his needing to be prompted to eat slowly and eat small pieces of food. Mr. Bruns informed me that the Discharge Instructions from Resident A's previous placement, Medi-Lodge, stated that he was on a "regular diet" and was able to eat independently. I asked Mr. Bruns to send me a copy of that report and he said he would. Mr. Bruns said that he did not know why it was written in Resident A's most recent Assessment Plan that he needed to be prompted to eat slowly and eat small pieces of food. He thought it must have been an oversight on the Home Manager's part. Mr. Bruns informed me that even if Resident A did need this type of prompting, it wouldn't be clear if staff members were also supposed to supervise him while he eats (i.e., sit next to him and watch him closely). He added that Resident A should have had a swallow test before being admitted to this home to see if there were any concerns regarding his swallowing food.

On 03/27/2019, I received the Medi-Lodge Discharge Instructions for Resident A from Mr. Bruns. The document is dated 05/11/2016 and confirms what Mr. Burns said, that Resident A was on a "regular diet" and was able to eat independently.

On 03/28/2019, I sent an email to Mr. Salmoni requesting the training transcripts for Ms. Hartman, Ms. Fries, and Ms. Little. That same day I received a return call from Mr. Salmoni. He wanted clarification on what I was requesting. He said he would send the transcripts to me soon.

On 03/28/2019, I received the training records from Mr. Salmoni and reviewed them. The records show that Ms. Hartman completed First Aid training on 12/01/2017 and CPR training on 07/27/2018; Ms. Fries completed First Aid training and CPR training

on 07/27/2018; and Ms. Little completed First Aid training and CPR training on 01/11/2019.

On 04/03/2019, I called and spoke with Andrea Bishop, Case Manager Supervisor with InterAct of Michigan. Ms. Bishop informed me that the process for delivering current PCPs to home staff is for a Clinical Records staff member to upload the plan within 15 days of completion to the CMH Streamline system. Providers (AFC Homes) know when PCPs are due for their residents and are expected to go to the CMH Streamline system to download the most current PCP. Ms. Bishop stated that Resident A's PCP dated 03/23/2018 was uploaded, but she would not give me the date because once a resident is deceased that information cannot be divulged. Ms. Bishop did say, however, that the report had to have been uploaded in order for InterAct to get approval to provide services to Resident A. Ms. Bishop told me that the system of uploading resident records into the CMH Streamline program has been in use for the past 6 years.

On 04/04/2019, I called and held an exit conference with Barry Bruns, Licensee Designee. I informed Mr. Bruns that I learned from the CMH Case Manager Supervisor that PCPs get uploaded into CMH's Streamline program and AFC personnel are expected to download them for the CMH residents they have in their homes, and that this has been the process for the past six years. Mr. Bruns acknowledged that he was aware of this, and stated he did not know why 691 W. Bridge Street AFC home did not have a current PCP for Resident A. I told Mr. Bruns that I was informed by the Case Manager Supervisor that Resident A's last PCP, dated 03/23/2018 was uploaded by a Clinical Records staff member within the required timeframe. I told Mr. Bruns that I was citing a violation of this rule because it states clearly in Resident A's most current Assessment Plan, dated 05/16/2018, as well as in his PCP, that "Staff should monitor for signs of chocking; staff should prompt for him to take small bites." In addition, there is a protocol in place for AFC staff to obtain the most current PCP for a resident and it appears that that was not done. Mr. Bruns said that CMH does not send a notice when the PCP has been uploaded. Mr. Bruns also expressed his concern that when Resident A was admitted to this home it was written in his discharge plan from Medi-Lodge that he was able to eat a "regular diet" and could eat "independently." He said that in order to know that Resident A required prompting to eat slowly and take small bites, testing should have been done, such as a swallow test. Mr. Bruns added that in the PCP it states that "protocols" for choking should be followed, but it doesn't give details as to what those protocols are. Regardless of these concerns, Mr. Bruns accepted my finding, and informed me that he has begun measures to help prevent something like this from happening again. He reported that he has had every resident in each of the 12 homes his company runs assessed for any eating complications and other potential risks, is having separate Risk Files for each resident who has certain risks and is having all of his staff perform case review meetings every week. Mr. Bruns said that he will write a corrective action plan for this violation and provide it to me ASAP.

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:	Resident A's Assessment plan, dated 05/16/2018, as well as his Needs Inventory for Personal Care and Community Living Supports (dated 03/23/2018) and his CMH Assessment (dated 02/12/2016) state that Resident A was at risk for choking while eating and needed to be prompted to eat slowly and to eat small, soft pieces of food. On 03/16/2019 Resident A was not prompted at dinnertime by any of the three staff members working at the time, Renata Hartman, Erin Little, and Amber Fries, to eat slowly and take small bites. Resident A ended up choking on a large piece of pork during that meal and died the following day in the hospital. Resident A was not provided the supervision, protection, and personal care as specified in his written assessment plan and other treatment and care plans.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend that the status of this home's license be modified to Provisional for the above summarized quality of care violation.

April 8, 2019

Ian Tschirhart, Licensing Consultant Date

Approved By:

April 8, 2019

Jerry Hendrick, Area Manager Date