GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 25, 2019

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

RE: License #: AM030353416
Investigation #: 2019A0350029
691 W. Bridge Street AFC

Dear Mr. Bruns:

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.

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 #:	2019A0350029
Complaint Receipt Date:	04/17/2019
Investigation Initiation Date:	04/17/2019
Report Due Date:	05/17/2019
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?
Staff member Renatta Hartman allowed Resident A to fall face-first into his bed and remain there for a few minutes without turning Resident A to his side to allow breathing. Ms. Hartman then turned Resident A to his back and threw his legs onto the bed which caused his foot to hit the leg rest of his wheelchair.	No
Additional Findings – Staff failed to administer Resident A's 8 p.m. dose of his diabetes medication, Metformin, for seven days in a row, from April 1 to April 7, 2019.	Yes
Additional Findings – Staff did not send the Licensing Consultant an Incident Report within the required timeframe after learning that Resident A had three fractured ribs.	Yes

III. METHODOLOGY

04/17/2019	Special Investigation Intake 2019A0350029
04/17/2019	Special Investigation Initiated - Letter I emailed Michael McClellan of Adult Services about this complaint
04/18/2019	Contact - Face to Face I met Michael McClellan, Adult Protective Services investigator, at this home and we interviewed staff and Resident A
04/18/2019	Contact - Telephone call made Mr. McClellan got Dara Smith, Resident A's Case Manager
04/19/2019	Contact - Telephone call received I spoke with Barry Bruns, Licensee Designee
04/19/2019	Contact - Document Received I receive an email from Mr. Bruns with an attached document
04/22/2019	Contact - Telephone call made I called and interviewed Renatta Hartman, DCW
04/25/2019	Exit Conference – Held with Barry Bruns, Licensee Designee

ALLEGATION: Staff member Renatta Hartman allowed Resident A to fall face-first into his bed and remain there for a few minutes without turning Resident A to his side to allow breathing. Ms. Hartman then turned Resident A to his

back and threw his legs onto the bed which caused his foot to hit the leg rest of his wheelchair.
INVESTIGATION: On 04/17/2019, I informed Michael McClellan, Adult Protective Services (APS) investigator of this complaint via email. I told him that I would be doing an onsite inspection on 04/18/2019 at 10 a.m. He replied that he would meet me there at that time.

On 04/18/2019, I met Mr. McClellan at the home and we interviewed Resident A, Direct Care Worker (DCW) Shannon Shilts, Home Manager Scott Salmoni, and Program Director Kevin Steve.

During the interview of Resident A, who is mostly nonverbal, I asked him if he remembered when Ms. Hartman and Ms. Shilts helped him to bed on 04/14 and he nodded "yes." I asked him if he fell on his bed and if his face was blocked so he couldn't breathe and denied this. I asked Resident A if Ms. Hartman threw his legs onto the bed and he shook his head "no," but said "fast" and motioned with his arm that she moved his legs fast onto the bed. I asked him if his foot hit his wheelchair in the process and he said "yes." After the interview, I requested two DCWs who were working during my onsite inspection to show Mr. McClellan and me Resident A's right foot, and they removed his shoe, sock, and compression stocking. I observed a very faint tan-colored bruise on his ankle that was about a half-inch high and two inches long. The staff members knew sign language and used it to relay the question I had for him as to what he hit his foot against, and he replied that he did not know.

During the interview of Ms. Shilts, she told Mr. McClellan and me that she worked from 6 a.m. on 4/14 to 12 a.m. on 04/15. She stated that at about 9:30 p.m. on 04/14, Resident A indicated that he was going to bed and Renatta Hartman, DCW, helped him. Ms. Shilts said that she was giving Ms. Hartman verbal instructions on how to lift and transfer Resident A and when Ms. Hartman lifted Resident A up he grabbed the bedrail but he ended up falling on the bed anyway. Ms. Shilts reported that Resident A fell face down and his mouth and nose were against the bedding so he had trouble breathing. Ms. Shilts said that he was in that position for "about a minute," and added that she wanted to help him but the wheelchair and food service tray on wheels were in the way. She told Mr. McClellan and me that when Ms. Hartman turned him over "he was pale" and "struggled to breathe". Ms. Shilts also stated that during this same incident, Ms. Hartman moved Resident A's legs onto his bed and in the process Resident A hit his right foot on his wheelchair, causing it to bruise. Ms. Shilts said it appeared that Ms. Hartman was not adept at transferring Resident A.

On 04/18/2019, Mr. McClellan and I spoke with Scott Salmoni, Home Manager, and Kevin Steve, Program Director. Mr. Salmoni informed us that Ms. Shilts told him about the incident on the night of 04/14 when Ms. Hartman was assisting Resident A to bed, but he did not provide the details of what Ms. Shilts told him. Mr. Steve told Mr. McClellan and me that when Ms. Hartman returns to work she will be put on third

shift. He added that Resident A may be moving to another facility soon that offers a higher level of care. I requested the document showing that Ms. Hartman completed a training on how to transfer residents. Mr. Salmoni provided this document to me and to Mr. McClellan before we left the home.

On 04/18/2019, I reviewed a document called Transfer Training Skills Check that shows Ms. Hartman completed this training on 10/25/2002.

On 04/22/2019, I called and spoke with Renatta Hartman. Ms. Hartman explained that when Resident A wanted to go to bed on the evening of 04/15/2019, she assisted him. Ms. Hartman said that Resident A did not fall on the bed, nor was he lying face down with his face in the bedding so he couldn't breathe. She stated that Resident A laid on his bed on his side. Ms. Hartman told me that it was a "possibility" that as she swung Resident A legs onto the bed his foot may have hit his wheelchair. She denied being too rough with him as she assisted him. Ms. Hartman reported that she looked at Resident A's foot after this incident and said that "it looked fine."

On 04/25/2019, I called and held an exit conference with Barry Bruns, Licensee Designee. I informed Mr. Bruns that I was not citing a violation of this rule because, although Ms. Shilts said that Ms. Hartman allowed Resident A to fall on his bed, left him with his face in the bedding so he couldn't breathe, and was careless when swinging Resident A's legs on his bed, Ms. Hartman and Resident A denied that Ms. Hartman let him fall onto his bed or that he was left so he couldn't breathe. The only thing that happened, according to Ms. Hartman and Resident A was Resident A hitting his foot against the wheelchair when Ms. Hartman swung his legs onto his bed. I observed the bruise, which was extremely faint. Mr. Bruns thanked me and had no further comment.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Resident A reported that Ms. Hartman threw his legs onto the bed "fast" and that his foot hit his wheelchair in the process. Resident A's right ankle had an extremely faint tan-colored bruise that was about a half-inch high and two inches long. Resident A denied that he fell on his bed and that his face was blocked by bedding so he couldn't breathe.

	Ms. Hartman said that Resident A did not fall on the bed, nor was he lying face down with his face in the bedding so he couldn't breathe. She stated that Resident A laid on his bed on his side. Ms. Hartman acknowledged that it was a "possibility" that as she swung Resident A legs onto the bed his foot may have hit his wheelchair and that she checked his foot and it was fine. Ms. Shilts reported that Ms. Hartman allowed Resident A to fall on his bed, did not assist him for a few minutes while his face was blocked by the bedding so he couldn't breathe, and that Ms. Hartman carelessly moved Resident A's legs to the bed, hitting his foot on his wheelchair in the process. However, Resident A and Ms. Hartman deny that Resident A fell on his bed and that his face was covered by bedding, causing him to have trouble breathing. A preponderance of evidence was not discovered through this investigation which would indicate Ms. Hartmen failed to protect Resident A or that she put his safety at risk.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING: Staff failed to administer Resident A's 8 p.m. dose of his diabetes medication, Metformin, for seven days in a row, from April 1 to April 7, 2019.

INVESTIGATION: On 04/18/2019, Mr. McClellan and I spoke with Scott Salmoni, Home Manager, and Kevin Steve, Program Director. Mr. Salmoni informed us that Ms. Hartman was given a five-day suspension for neglecting to give Resident A his Metformin four days in a row. Mr. Steve told Mr. McClellan and me that when Ms. Hartman returns to work, she will be put on third shift. He added that Resident A may be moving to another facility soon that offers a higher level of care. I requested copies of the Incident Reports regarding the medication not being given to Resident A and Mr. Salmoni provided these documents to me and to Mr. McClellan before we left the home.

An Incident Report dated 04/08/2019 states that "Both staff RH & AF noticed that (Resident A's) Metformin 500 mg was not passed, initial or dotted between 4/1 to 4/7. Staff AF passed 8pm Metformin. Notified lead supervisor & admin-on call of situation [sic]."

On 04/19/2019, Mr. Bruns sent me an email stating, "Attached is medication sheet for resident taking Metformin. On the middle of the second page you'll see the resident takes Metformin twice per day at 8 AM and 8 PM. It was the 8PM dose that

was not given from April 1 – 7, 2019." I reviewed the Medication Administration Record (MAR) and observed what Mr. Bruns had said; that Resident A was not given his 8 p.m. dose of Metformin from 04/01 to 04/07.

On 04/22/2019, I called and spoke with Renatta Hartman. Ms. Hartman confirmed that she was currently on suspension from work because she failed to administer some of Resident A's 8 p.m. Metformin medications between 04/01 and 04/07 because she "couldn't find them." Ms. Hartman added that she was not the only DCW who failed to administer this medication to Resident A during that time period.

On 04/23/2019, I called and held an exit conference with Barry Bruns, Licensee Designee. I informed Mr. Bruns that I was citing a violation of this rule because staff neglected to administer Resident A's 8 p.m. diabetes medication, Metformin, seven days in a row. Mr. Bruns reminded me that he sent me the MARs regarding this and had no further comment.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Home Manager, Scott Salmoni, informed me that staff member Renatta Hartman was placed on a 5-day suspension for not passing Resident A's 8 p.m. dose of Metformin for several days in a row. Ms. Hartman acknowledged that she did not administer Resident A's Metformin medication because she "couldn't find it." Resident A did not receive his 8 p.m. dose of Metformin for seven days in a row, from 04/01 to 04/07/2019.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Staff did not send the Licensing Consultant an Incident Report within the required timeframe after learning that Resident A had three fractured ribs.

INVESTIGATION: While in private at the home on 04/18/2019, Mr. McClellan got Dara Smith, Resident A's Case Manager from Kalamazoo County Community Mental Health, on speakerphone. Ms. Smith informed us that Resident A complained of pain about three weeks ago and was taken to the hospital where he was found to have three fractured ribs. The cause of the fractured ribs was uncertain. Ms. Smith said that she was looking into another placement for Resident A where he can receive "a higher level of care."

On 04/18/2019, Mr. McClellan and I spoke with Scott Salmoni, Home Manager, and Kevin Steve, Program Director. Mr. Salmoni stated that about three or four weeks ago Resident A complained of "back pain" and was taken to Borgess-PIPP Hospital where they diagnosed him as having three fractured ribs. I requested a copy of the Incident Report regarding Resident A's fractured ribs and a copy of the medical report pertaining to his fractured ribs and he provided a set of these documents to me and to Mr. McClellan before we left the home.

On 04/18/2019, I reviewed the Incident Report and Medical Report pertaining to Resident A's fractured ribs. An Incident Report dated 03/14/2019 states "(Resident A) asked staff to use the phone. 10 minutes later, he's by the door yelling for staff. Staff JD went over to him and he said, 'they're here.' Staff JD looked out the window and saw an ambulance and a police car. (Resident A) called the ambulance because he has pain near his ribs. Staff RH, JD, and EL all told (Resident A) that the hospital can't do anything with ribs if they're broken or bruised and he still wanted to go [sic]."

The Patient Summary report dated 03/14/2019 states that Resident A was seen by Dr. Eric Blackwell, MD, and Emergency Department Care Provider. The report states that the "Chief Complaint" was for a "Fall" and that Resident A was diagnosed with a fractured rib. The report from a follow up visit with Dr, Sheikh on 03/19/2019 states that Resident A has fracture to his 6th rib. Follow up instructions in this report say "Please make sure pt. sits in his chair straight instead of leaning (indiscernible) L side."

On 04/19/2019, I checked my files and did not find an Incident Report regarding Resident A being taking to the hospital for his rib pain.

On 04/19/2019, I received a call from Barry Bruns, Licensee Designee. He reported that Resident A broke the toilet while sitting on it on 03/11 but didn't complain of painful ribs until 03/14. I informed Mr. Bruns that I did not receive an Incident Report for the medications that were not passed to Resident A for four days, nor did I receive one for the hospital or doctor's visit regarding Resident A's painful ribs.

On 04/19/2019, I received an email from Mr. Bruns with an attached document. In his email, Mr. Bruns stated:

"Dr. Shaikh (phone 269-343-2601) was the physician who saw the resident for follow up visit on 3/19/2019 regarding rib fracture. Attached is the physician visit record. The employee who accompanied resident to this appointment was Diamond Smith (313) 414-1212. (not Shannon Shilts as we discussed). Ms. Smith attached a statement to the physician record clarifying physician's statement (see second page of attachment). The resident saw Dr. Shaikh again on 3/27/2019 for bed sores and on 4/3/2019 for bed sores and shoulder pain.

Regarding IRs, it might be helpful in the future if we send IRs to you via secure email versus fax. This might be more efficient and would allow us to keep a better record of IRs sent. Let me know if that would work for you, or if you still prefer to receive IRs via fax."

The attachment Mr. Bruns sent me was an Incident Report dated 04/18/2019, but it was regarding the follow-up doctor visit on 03/19/2019, not the incident in which he was first taken to the hospital for his rib pain. The Incident Report, written by Diamond Smith, DCW, states, "(Resident A) complain to doctor about some pain on his side. Pt was told by dr. Shaik that it could be from leaning in the chair."

On 04/23/2019, I called and held an exit conference with Barry Bruns, Licensee Designee. I informed Mr. Bruns that I was citing a violation of this rule because I did not receive an Incident Report regarding Resident A's fractured ribs within the 48-hour time requirement. In fact, I was only provided this Incident Report when I requested it, which was about a month after the incident occurred. Mr. Bruns stated that he advised his staff to send Incident Reports to me through emails from now on and had no further comment.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division with 48 hours of any of the following: **(b) Any accident or illness that requires hospitalization.**
ANALYSIS:	Resident A complained of pain to his side on 03/14/2019 and was taken to the hospital where he was diagnosed as having three fractured ribs.

	An Incident Report regarding this injury and hospitalization was not sent to me within the 48-hour required period. I received the Incident Report about a month afterwards, and only after I requested it.
CONCLUSION:	**VIOLATION ESTABLISHED**

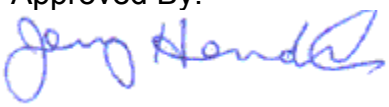
IV. RECOMMENDATION

Special investigation 2019A0350025 resulted in a recommendation for a provisional license on 04/08/2019. Upon the receipt of an acceptable corrective action plan addressing the violations cited in this special investigation report, this recommendation remains unchanged.

April 25, 2019

Ian Tschirhart — Date
Licensing Consultant

Approved By:



April 25, 2019

Jerry Hendrick — Date
Area Manager