GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 27, 2019

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

RE: License #: AS390078924
Investigation #: 2019A0578036
10713 South 12th 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.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Eli DeLeon, Licensing Consultant
Bureau of Community and Health Systems
322 E. Stockbridge Ave
Kalamazoo, MI 49001
(269) 251-4091

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390078924
Investigation #:	2019A0578036
Complaint Receipt Date:	05/08/2019
Investigation Initiation Date:	05/08/2019
Report Due Date:	07/07/2019
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:	10713 South 12th Street AFC
Facility Address:	10713 South 12th St Portage, MI 49087
Facility Telephone #:	(269) 372-4820
Original Issuance Date:	11/06/1997
License Status:	REGULAR
Effective Date:	08/11/2018
Expiration Date:	08/10/2020
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A is not being assisted with bathing.	No
Resident A is not being transported to medical appointments.	No
Resident B was prescribed 40mg of Prednisone but only received 10mg on 06/08/2019.	Yes

III. METHODOLOGY

05/08/2019	Special Investigation Intake-2019A0578036
05/08/2019	Special Investigation Initiated – Telephone with staff member Tria Williams.
05/08/2019	APS Referral Completed
05/13/2019	Special Investigation Completed On-site -Interviewed Resident A, staff members Emily Taylor, Ashley Polino and Tria Williams.
05/13/2019	Contact-Document Received -*AFC Incident / Accident Report*, 05/03/2019, 05/04/2019, 05/04/2019.
06/13/2019	Additional Allegations Received-Intake #165216.
06/13/2019	Special Investigation Completed On-site Interviewed staff members Emily, Taylor, Ashley Polino and Resident B.
06/14/2019	Contact-Document Received-*Assessment Plan for AFC Residents,* Resident A.
06/14/2019	Contact-Document Received -*Shower Tracking, HomeLife inc. 1:1 Progress Note.*
06/14/2019	Contact-Telephone -Interview with Senior Services support consultant Lorie Wilfong.
06/19/2019	Contact-Telephone -Interview with KCMHSAS recipient rights officer Michele Shiebel.
06/20/2019	Exit Conference-With the licensee, Barry Bruns

ALLEGATION:
Resident A is not being assisted with bathing.

INVESTIGATION:
On 05/08/2019, I received this complaint through the BCHS On-line Complaint System. Complainant alleged that Resident A is not provided with necessary assistance when bathing. No additional information was provided.

On 05/13/2019, I completed an unannounced investigation on-site at this facility and interviewed Resident A regarding the allegations. Resident A stated that it has been two weeks since she had last showered and acknowledged taking a shower just before my arrival. Resident A stated that she requires assistance when dressing and bathing and acknowledged that staff provide this for her. Resident A clarified the facility has new direct care staff and she is uncomfortable with new staff providing her with assistance, as she is unsure these staff have been trained properly in how to provide assistance. Resident A denied having any negative experiences with new staff but clarified that she would rather take a shower on her own if new staff were her only option. Resident A acknowledged this has resulted in her refusing assistance in the shower when offered or prompted by staff.

While at the facility I reviewed the details of the allegations with direct care staff member Ashley Polino and staff member Tria Williams. Ms. Polino acknowledged that Resident A sometimes requires assistance in the shower but denied that she is ever refused assistance in the shower. Ms. Polino clarified that it is Resident A who will refuse assistance provided by direct care staff to shower. Ms. Polino reported that Resident A is provided 1:1 staffing specifically for personal care and every staff at this facility is trained in transferring residents. Ms. Polino stated it is common for Resident A to refuse this assistance. Ms. Polino provided *Shower Tracking* forms and *HomeLife Inc. 1:1 Progress / Note Time Sheets* for Resident A. Ms. Polino provided documentation that all staff were provided training in transferring residents. I observed staff schedules which reflected 1:1 staffing provided to Resident A daily, between the hours of 7AM and 3PM.

While at the facility I reviewed the details of the allegations with direct care staff member Emily Taylor. Ms. Taylor denied the allegations, stating that staff complete the *Shower Tracking* forms and *HomeLife Inc. 1:1 Progress / Note Time Sheets* for Resident A. Ms. Taylor clarified that Resident A is approved through Kalamazoo Community Mental Health and Substance Abuse Services (KCMHSAS) for 1:1 staffing specifically for assistance with bathing. Ms. Taylor clarified that Resident A is incentivized to complete her showering and bathing tasks regularly with a professional hair appointment at the expense of the facility.

On 05/13/2019, I reviewed the following *AFC Incident/Accident Report* on file at this facility relating to Resident A. On 05/03/2019, it was documented that Resident A refused to shower and told staff that she was, “not getting into it.” On 05/04/2019, Resident A refused to shower and told staff that her therapist told her she didn’t

have to. Also, on 05/04/2019, Resident A was offered assistance with showering when she told staff that she would “pass.”

On 06/14/2019, I reviewed the *Assessment Plan for AFC Residents* (assessment plan) completed for Resident A on 12/12/2018. This assessment plan stated that Resident A needs help washing hard to reach areas and help braiding and brushing her hair.

On 06/14/2019, I reviewed Resident A’s *Shower Tracking* form for May 2019 and June 2019. This form completed by facility direct care staff indicated that Resident A is routinely offered assistance with showering or washing and has refused this assistance on 20 different occasions for the month of May. This combination of data indicated that Resident A completed showering or washing independently on at least 11 different occasions during the month of May. For the month of June, Resident A completed showering or washing on at least three different occasion until the end of reporting on 06/14/2019. For this same period of time, Resident A refused assistance with showering or washing on at least 23 different occasions, with prompting occurring in the morning and in the evening.

On 06/14/2019, I reviewed Resident A’s *HomeLife Inc. 1:1 Progress/Note Time Sheet* from 04/29/2019 until 06/14/2019. During this period, Resident A was provided additional and personal 1:1 staffing every day from 07:00AM to 03:00PM. The activities or progress that was logged daily indicates that Resident A was transported from her bedroom to the bathroom, provided assistance with lotion and socks and selecting clothing, as well as assistance with combing and braiding her hair. This documentation reflects that Resident A showered on three different occasions during this time period.

On 06/14/2019, I interviewed Senior Services supports consultant Lori Wilfong regarding the allegations. Ms. Wilfong stated she was newly assigned to Resident A but had reviewed her concerns related to the amount of assistance that she requires while showering. Ms. Wilfong denied that Resident A requires three staff to assist while showering, stating there is nothing in Resident A’s needs inventory to suggest that she physically needs that amount of care. Ms. Wilfong reported that Resident A’s showering and bathing preferences seem to indicate that she can complete them on her own, unless one of her preferred staff is available, which results in this staff providing Resident A with assistance. Ms. Wilfong acknowledged the level of care Resident A requires may be more behavioral and confusing to staff. Ms. Wilfong reported that she believes the facility is doing their best to meet the needs of Resident A, stating the facility has paid for Resident A to have her hair professionally done since it is extremely long and requires a long time to dry. Ms. Wilfong reported that it is not uncommon for Resident A to refuse showering assistance provided by staff she is unfamiliar with. Ms. Wilfong stated Kalamazoo Community Mental Health and Substance Abuse Services has authorized Resident A to receive 1:1 assistance with personal hygiene.

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	During the unannounced on-site investigation, I observed *Shower Tracking* and *HomeLife Inc. 1:1 Progress/Note Time Sheets* specific to Resident A that documented the frequency that staff prompted and offered assistance to Resident A. This documentation showed that Resident A was offered prompting and assistance with showering or bathing at least twice a day and refused. I reviewed several *AFC Incident/Accident Reports* that documented staff prompts and Resident A's refusal to shower or bath. During interviews, staff members Emily Taylor and Ashely Polino agreed that Resident A was provided 1:1 staffing and incentives to complete a regular shower or bathing routine. Senior Services supports consultant Lori Wilfong reported that Resident A is approved for 1:1 assistance with personal hygiene and clarified the level of assistance requested by Resident A is not consistent with her annual needs inventory. During the unannounced investigation on-site, I observed staff schedules which reflected 1:1 staffing provided to Resident A daily, between the hours of 7AM and 3PM. As such, there is no evidence that Resident A is not afforded the opportunity for daily bathing or provided the necessary assistance from staff to do so.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:
Resident A is not being transported to medical appointments.

INVESTIGATION:
On 05/08/2019, I received this complaint through the BCHS On-line Complaint System. Complainant alleged that Resident A is not provided with transportation to medical appointments. No additional information was provided.

On 05/13/2019, I completed an unannounced investigation on-site at this facility and interviewed Resident A regarding the allegations. Resident A acknowledged that direct care staff transport her to all of her medical appointments, with the exception of her last appointment with Kalamazoo Gastroenterology. Resident A stated this

appointment was rescheduled for a later date and she didn't understand why. Resident A clarified this facility is much better that other facilities that she is aware of but added that she didn't like that her appointment was changed. Resident A denied ever missing an appointment due to direct care staff refusing to provide her transportation.

While at the facility I reviewed the details of the allegations with staff member Ashley Polino and staff member Tria Williams. Ms. Polino and Ms. Williams acknowledged that Resident A recently missed an appointment with Kalamazoo Gastroenterology due to staff not being able to print a necessary medical appointment record. Ms. Polino elaborated that her office printer was not working properly, and this had been reported to the administration in order to facilitate repairs. Ms. Polino stated the appointment with Kalamazoo Gastroenterology was rescheduled for 06/13/2019. Ms. Polino stated this missed appointment was the exception, but it is common for Resident A to refuse to attend certain appointments.

While at the facility, I reviewed the *AFC-Resident Care Agreement* completed for Resident A. This agreement was completed on 12/12/2018 and stated that program related transportation will be provided within Kalamazoo County, and is included with the agreed upon basic fee.

On 06/14/2019, I reviewed the details of this allegations with Senior Services Supports Consultant Lori Wilfong. Ms. Wilfong denied any concerns about the facility providing transportation to necessary medical appointments, stating Resident A has a history of refusing medical appointments for a variety of reasons, and then falsely accusing others for being responsible for her missed appointments. Ms. Wilfong stated that Resident A's previous supports consultant was fired by Resident A for missing an appointment that Resident A has refused and rescheduled with short notice.

On 06/14/2019, I contacted staff member Tria Williams regarding Resident A's rescheduled appointment with Kalamazoo Gastroenterology. Ms. Williams reported this appointment was completed and provided a copy of the corresponding medical appointment record and patient plan developed by Kalamazoo Gastroenterology. This document states Resident A was provided dietary management education, guidance and counseling on 06/13/2019

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	((6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and

	which specifies the responsibilities of each party. A resident care agreement shall include all of the following: **(a) An agreement to provide care, supervision, and protection, and to assure transportation services to the resident as indicated in the resident's written assessment plan and health care appraisal.** **(d) A description of the transportation services that are provided for the basic fee that is charged and the transportation services that are provided at an extra cost.**
ANALYSIS:	During an unannounced investigation completed on-site, I interviewed Resident A, who acknowledged never being refused transportation to medical appointments but expressed dissatisfaction with having a medical appointment rescheduled. I verified this rescheduled appointment occurred on 06/13/2019. I interviewed staff members Ashley Polino and Tria Williams, who denied that Resident A is not provided transportation to medical appointments, clarifying that one recent appointment was rescheduled. Senior Services support consultant Lori Wilfong denied having any concerns about the facility providing transportation for Resident A to necessary appointments and acknowledged that Resident A will sometimes refuse appointments. I reviewed Resident A's *AFC-Resident Care Agreement,* which identified that program related transportation is provided within Kalamazoo County. As such, there is no evidence the licensee is not providing and assuring transportation for Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:
Resident B was prescribed 40mg of Prednisone but only received 10mg on 06/08/2019.

INVESTIGATION:
On 06/13/2019, I received an additional complaint through the BCHS On-line Complaint System. Complainant alleged Resident B only received one dose of his Prednisone, which was 10 mg, but was prescribed to receive 40 mg not 10 mg. Complainant alleged that a risk of harm assessment was completed related to this missing medication and could have resulted in death.

On 06/13/2019, I completed an unannounced investigation on-site at this facility and reviewed the details of the allegations with staff members Emily Taylor and Ashley

Polino. Ms. Polino reported that she had not been working the last few days, but it was reported to her that a staff member had only passed one pill of 10mg of Prednisone instead of four pills of the prescribed 40mg of Prednisone. Ms. Polino reported that Resident B was previously treated at a hospital for emphysema, and at a follow up appointment was prescribed Prednisone. Ms. Polino explained this medication was to be administered for several days and then decrease in small decrements over several days. While at the facility I reviewed the medication administration record for Resident B. This record clearly shows that Resident B was to receive 40 mg of Prednisone once daily for three days on 06/08/2019, 06/09/2019, and 06/10/2019. Resident B was to then receive 30 mg of Prednisone on 06/11/2019, 06/12/2019, and 06/13/2019. This pattern continued until 06/19/2019.

While at the facility, I reviewed an *AFC Incident / Accident Report* that was completed by staff member Ranya Rolland on 06/10/2019. The report states that Resident B was passed one prednisone 10mg pill instead of the total of 40mg on 06/08/2019. The report states that staff informed the lead (supervisor).

While at the facility, staff member Tria Williams was interviewed by phone. Ms. Williams acknowledged that staff member Ranya Williams reported to her that Resident B did not receive all of his prescribed medications. Ms. Williams denied calling an appropriate health care professional regarding the missing medication, stating it was the weekend and she was not sure if one would be available.

While at the facility, I interviewed Resident B. Resident B did not recall missing any medications and denied having any concerns, stating staff members provide him with all his necessary medications.

On 06/19/2019, I reviewed the details of the allegations with Kalamazoo Community Mental Health (KCMHSAS) recipient rights officer Michele Schiebel. Ms. Schiebel confirmed that a risk of harm assessment related to this missing medication was completed by a health care professional, who clarified that missing this medication could have caused an asthma attack or restricted airway, which could have prevented Resident B from obtaining necessary emergency medical care and lead to death. Ms. Schiebel acknowledged that Resident B had just been prescribed this medication, but clarified that Resident B was prescribed the medication as a result of breathing issues.

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:	During an unannounced on-site investigation, I interviewed staff members Ashley Polino and Tria Williams, who acknowledged that Resident B did not receive the prescribed dosage of Prednisone medication on 06/08/2019. While at the facility I reviewed an *AFC Incident / Accident Report* completed by staff member Ranya Rolland where she acknowledged not administering Resident B his Prednisone medication as prescribed and reporting it to her supervisor. As such, there is enough evidence to support that on 06/08/2019 Resident B did not receive his Prednisone medications as prescribed by a physician.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
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.
ANALYSIS:	During an interview with staff member Tria Williams, Ms. Williams acknowledged the missing dosage of Prednisone medication was not reported to the appropriate health care professional, and no additional instructions from an appropriate health care professional relating to this medication error were obtained.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

06/20/2019

_____

Eli DeLeon Date
Licensing Consultant

Approved By:

06/27/2019

_____

Dawn N. Timm Date
Area Manager