GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 17, 2021

Judith Dunton
Michigan Community Services, Inc.
PO Box 317
Swartz Creek, MI 48473

RE: License #:	AS250263591
Investigation #:	2021A0872023
	Farmtree Home

Dear Ms. Dunton:

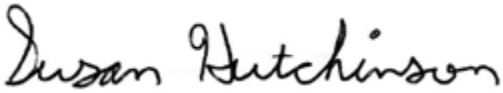
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (810) 787-7031.

Sincerely,



Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
4809 Clio Road
Flint, MI 48504
(989) 293-5222

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250263591
Investigation #:	2021A0872023
Complaint Receipt Date:	04/13/2021
Investigation Initiation Date:	04/13/2021
Report Due Date:	06/12/2021
Licensee Name:	Michigan Community Services, Inc.
Licensee Address:	5239 Morrish Rd. Swartz Creek, MI 48473
Licensee Telephone #:	(810) 635-4407
Administrator:	Lena Crosson
Licensee Designee:	Judith Dunton
Name of Facility:	Farmtree Home
Facility Address:	9436 Farmtree Drive Swartz Creek, MI 48473
Facility Telephone #:	(810) 635-0580
Original Issuance Date:	03/03/2004
License Status:	REGULAR
Effective Date:	09/13/2020
Expiration Date:	09/12/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 4/10/21, staff noticed Resident A's right leg was swollen, greenish, and warm to the touch. He was sent to McLaren ER where he was diagnosed with a fracture to his right leg and pneumonia. The cause of the injury is unknown.	Yes

III. METHODOLOGY

04/13/2021	Special Investigation Intake 2021A0872023
04/13/2021	APS Referral I made an APS complaint regarding these allegations
04/13/2021	Special Investigation Initiated - Letter
04/14/2021	Contact - Document Received I received a referral from GHS
04/21/2021	Contact - Document Sent I exchanged emails with APS worker, Dan Spalthoff
05/03/2021	Contact - Document Sent I emailed the administrator, Lena Crosson, and asked for information related to Resident A
05/04/2021	Contact - Telephone call made I interviewed staff Angel Chatmon
05/04/2021	Contact - Telephone call made I interviewed staff Jacquetta Davis
05/05/2021	Contact - Document Received Documentation received from administrator
05/11/2021	Contact - Telephone call made I spoke to Mr. Spalthoff about this complaint
05/12/2021	Contact - Telephone call made I interviewed Guardian A1
05/17/2021	Exit Conference

	I conducted an exit conference with the licensee designee, Judy Dunton, via email
05/17/2021	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: On 4/10/21, staff noticed Resident A's right let was swollen, greenish, and warm to the touch. He was sent to McLaren ER where he was diagnosed with a fracture to his right leg and pneumonia. The cause of the injury is unknown.

INVESTIGATION: On 4/13/21, I reviewed an Incident/Accident Report dated 4/10/21 at 9:45am completed by staff Angel Chatmon. According to the report, Ms. Chatmon noticed that Resident A's right leg, "from the lower thigh down was swollen, greenish, and warm to the touch." Staff notified management and contacted 911. Resident A was transported to the hospital where he was admitted and diagnosed with a fracture to his right leg and pneumonia. Management is conducting an internal investigation.

On 4/14/21, I received a referral from Genesee Health Systems Recipient Rights Officer, Michelle Salem regarding the injury to Resident A.

On 4/23/21, I conducted an unannounced onsite inspection of Farmtree Home Adult Foster Care facility. I interviewed staff Karol Robertson and observed Resident A. Ms. Robertson said that she has worked at this facility since January 2019. She said that she worked 2nd shift on 4/09/21 and left at 7:00pm. Ms. Robertson said that when she left, Resident A was fine. On the morning of 4/10/21, staff Jacquetta Davis called her and told her about Resident A's leg. Ms. Robertson explained that Resident A is completely incontinent, unable to communicate, and is quadriplegic. He uses a Hoyer lift but is still able to stand a pivot for some staff when they are transferring him. She said that sometimes, when staff attempt to transfer him using the pivot, he will buckle his legs so staff will use the Hoyer lift. Ms. Robertson stated that during the night, staff checks on Resident A every two hours and if his brief is wet, staff will change him while he is lying in bed. I observed Resident A who was lying in bed, taking a nap. He had a cast on his right leg from above his knee to his foot. There were bed rails on his bed. Ms. Robertson said that Resident A does not have a history of falling out of bed and he does not receive physical or occupational therapy from an outside source. She said that staff does upper body exercises with him, but they do not do any lower body exercises. Ms. Robertson said that she has no idea how Resident A received the injury to his leg.

On 5/04/21, I interviewed staff Angel Chatmon via telephone. Ms. Chatmon said that she has worked at Farmtree Home AFC for approximately four years. She said that on 4/10/21, she got to work at 5:30am. She said that within an hour of arriving for work, she began her rounds of the residents, and checked on Resident A. She said that he was in bed, covered up and was dressed in a t-shirt and brief. She rolled him to the side to check his brief and since it was dry, she rolled him back over, covered him up and left

the room. Shortly thereafter, she prepared Resident A's breakfast which she took to his room. She said that she put his pajama pants on, pivoted him in the bed and put him in his wheelchair. She fed him breakfast and after he was finished, she transferred him back to his bed, covered him up and left the room. Ms. Chatmon said that later that morning, her co-worker Jacquetta Davis was getting ready to get Resident A dressed for the day and called her over because she was concerned about his leg. Ms. Chatmon said that she and Ms. Davis noticed that Resident A's leg appeared swollen, there was a greenish bruise, and it was hot to the touch. At that point, they contacted management and 911 and Resident A was taken to the hospital.

Ms. Chatmon said that she has thought about the injury a lot and has thought back to everything she did that morning and leading up to the injury and she cannot figure out how the injury may have occurred. Ms. Chatmon told me that although Resident A is non-verbal, he "is a goof" and he will laugh when he finds something funny and will blow kisses at her and other staff. According to Ms. Chatmon, Resident A was acting "normal" all day and was even laughing and blowing kisses while they were waiting for the ambulance to come and take him to the hospital.

On 5/04/21, I interviewed staff Jacquetta Davis via telephone. Ms. Davis said she has worked at Farmtree Home AFC for 10 years. She said that on 4/10/21, she arrived to work at 5:30am. She was the med passer that day so sometime between 6:30am-7:00am, she went into Resident A's room, raised the head of his bed, administered his medications, and left the room. Later that morning, she went into Resident A's room to get him dressed for the day. She pulled his pajama pants down and noticed that his leg was swollen, shiny, and there was a greenish bruise near the bottom. She called Ms. Chatmon over to look and they both agreed that his leg appeared injured, so they called management and 911. Ms. Davis said that Resident A did not give any indication that he was in pain or in distress. He was acting "normal" and was still laughing and blowing kisses to her and Ms. Chatmon right up until EMS arrived to take him to the hospital. Ms. Davis said that Resident A does not have a history of falls and to her knowledge, he did not have any accidents that could have caused an injury such as this.

On 5/05/21, I received documentation from the administrator, Lena Crosson, about this investigation. I reviewed Resident A's paperwork from McLaren Regional Medical Center which shows that he was treated for a "minimally displaced right proximal tibial shaft fracture."

Ms. Crosson obtained written statements from the following staff which I reviewed: Shasta Spearman, Chayla Clussel, Rosemary Hawks, Angel Chatmon, Jacquetta Davis, and Karol Robertson. Ms. Spearman worked on 4/09/21 from 9:30pm-5:30am. She said that she was assigned to Resident A and throughout her shift, she repositioned him 3x's. She changed one soiled brief and last checked on him at 4:40am. Ms. Spearman said that she did not notice any problems with Resident A during her shift.

Ms. Classel worked on 4/09/21 from 1:30pm-9:30pm. She said that Resident A was "fine all shift." She changed his brief at 9:20pm and noticed "nothing out of the ordinary."

Ms. Hawks worked on 4/09/21 from 9:30pm-5:30am but said she did not provide direct care to Resident A.

Ms. Chatmon worked on 4/09/21 from 1:30pm-8:00pm but did not provide direct care to Resident A. She also worked on 4/10/21 from 5:30am-1:30pm. She said that during that shift, her co-worker called her over to look at Resident A's leg which was "hot, light green, and swollen." Management was contacted and Resident A was transported to the hospital.

Ms. Davis worked on 4/10/21 from 5:30am-1:46pm. She said that at 9:45am she was getting Resident A dressed and noticed that his right leg from his lower thigh down was swollen, greenish, and warm to the touch. Her co-worker contacted management who said to call 911. Ms. Davis said that when EMS arrived, they asked her if Resident A had fallen, and she told them that to her knowledge, he had not fallen during their shift and that they had never gotten Resident A out of bed.

Ms. Robertson worked on 4/09/21 from 11:30am-7:00pm in a management role and she did not provide direct care to Resident A. She said that staff did not report any injuries to her during that shift. She stated that on 4/10/21, staff called and told her about Resident A's leg, so she instructed them to contact 911. She met Resident A at the hospital.

Resident A was admitted to Farmtree Home on 12/31/03. According to Resident A's Genesee County Individualized Plan of Service dated 8/26/20, Resident A is diagnosed with cerebral palsy with right hemiparesis, microcephaly, seizure disorder, contractures in right upper and lower extremities, and Kyphosis. He has a history of GI distress, uses a wheelchair and posey rolls on the sides of his bed as well as bed rails, and he requires assistance with all transfers.

On 5/12/21, I interviewed Guardian A1 via telephone. Guardian A1 said that due to Covid-19, he has not seen Resident A since January 2020. He said that the facility did notify him about Resident A's injury. He told me that he thinks staff told him that Resident A had fallen out of bed which is how he received the injury. According to Guardian A1, he feels that Resident A receives good care at Farmtree Home and does not believe that anyone would have deliberately harmed Resident A.

On 5/17/21, I conducted an exit conference with the licensee designee, Judith Dunton. I explained which rule violation I am substantiating and told her that once my report is approved, I will send her a copy requesting a corrective action plan.

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:	On 4/10/21, Resident A sustained a fracture to his right leg and the cause of the injury is unknown. Staff Rosemary Hawks worked on 4/09/21 from 1:30pm-9:30pm and said that she did not provide any direct care to Resident A. Staff Angel Chatmon worked on 4/09/21 from 1:30pm-8:00pm and said that she did not provide any direct care to Resident A. Staff Chayla Clussel said that she worked on 4/09/21 from 1:30pm-9:30pm. She stated that he seemed “fine all shift.” She changed his brief at 9:20pm and noticed “nothing out of the ordinary.” Staff Shasta Spearman said she worked on 4/09/21 from 9:30pm-5:30am. She said that she repositioned him 3x’s during the night and changed one soiled brief. She last checked on him on 4/10/21 at 4:40am and did not note any injuries. Staff Angel Chatmon worked on 4/10/21 from 5:30am-1:30pm. During my phone interview with her on 5/04/21, she told me that during the morning on 4/10/21, she put Resident A’s pajama pants on, got him out of bed and into his wheelchair and fed him breakfast. Once he was finished, she put him back in bed. Later that morning, staff Jacquetta Davis alerted her that Resident A’s right leg appeared swollen, greenish, and warm to the touch. Staff Jacquetta Davis worked on 4/10/21 from 5:30am-1:46pm. She said that at 9:45am she was getting Resident A dressed and noticed that his right leg from his lower thigh down was swollen, greenish, and warm to the touch. Resident A does not have a history of falls and according to his Health Care Appraisal and IPOS, there is no history of a medical condition that would cause this injury.

	I conclude that due to the severity of this injury and the fact that the cause is unknown, there is sufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.

Susan Hutchinson May 17, 2021

Susan Hutchinson Licensing Consultant	Date

Approved By:

Mary Holton May 17, 2021

Mary E Holton Area Manager	Date