GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 27, 2021

Jonathan Harland
Community Home & Health Services LLC
657 Chestnut Ct
Gaylord, MI 49735

RE: License #: AS690382137
Investigation #: 2022A0009002
Brackenwood

Dear Mr. Harland:

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 the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- A specific time frame for the 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 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 (231) 922-5309.

Sincerely,

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 350-0939

enclosure

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

## I. IDENTIFYING INFORMATION

| **License #:** | AS690382137 |
|---|---|
| | |
| **Investigation #:** | 2022A0009002 |
| | |
| **Complaint Receipt Date:** | 10/06/2021 |
| | |
| **Investigation Initiation Date:** | 10/06/2021 |
| | |
| **Report Due Date:** | 11/05/2021 |
| | |
| **Licensee Name:** | Community Home & Health Services LLC |
| | |
| **Licensee Address:** | 657 Chestnut Ct<br>Gaylord, MI 49735 |
| | |
| **Licensee Telephone #:** | (989) 732-6374 |
| | |
| **Administrator:** | Jonathan Harland |
| | |
| **Licensee Designee:** | Jonathan Harland, Designee |
| | |
| **Name of Facility:** | Brackenwood |
| | |
| **Facility Address:** | 3214 Hayes Tower Rd.<br>Gaylord, MI 49735 |
| | |
| **Facility Telephone #:** | (989) 732-9464 |
| | |
| **Original Issuance Date:** | 05/27/2016 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 11/27/2020 |
| | |
| **Expiration Date:** | 11/26/2022 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>DEVELOPMENTALLY DISABLED<br>MENTALLY ILL |

## II. ALLEGATION(S)

| Allegation | Violation Established? |
| --- | --- |
| A direct care worker pinched Resident A's nose until he opened his mouth to receive his medication. | Yes |

## III. METHODOLOGY

| Date | Activity |
| --- | --- |
| 10/06/2021 | Special Investigation Intake<br>2022A0009002 |
| 10/06/2021 | Special Investigation Initiated – Telephone call received from administrator Ms. Kris Rambo, Community Home and Health Services |
| 10/11/2021 | Inspection Completed On-site<br>Interview with home manager Ms. Cindy Wilkenson<br>Face to face contact with Resident A |
| 10/25/2021 | Contact – Telephone call made to direct care worker Ms. Amanda Bergy |
| 10/25/2021 | Contact – Telephone call made to direct care worker Ms. Shawn Adams |
| 10/27/2021 | Exit conference with licensee designee/administrator Mr. Jonathan Harland |

**ALLEGATION: A direct care worker pinched Resident A's nose until he opened his mouth to receive his medication.**

**INVESTIGATION:** I received a telephone call from Ms. Kris Rambo on October 6, 2021. Ms. Rambo is an administrator with Community Home and Health Services. She reported that there was incident at the Brackenwood adult foster care (AFC) home that was recently reported. She stated that direct care worker Ms. Amanda Bergy had pinched Resident A's nose until he opened his mouth to take a breath. She then put his medication into his mouth. Another direct care worker Ms. Shawn Adams observed this happen and came forward with the information. Ms. Bergy reportedly admitted that she had pinched Resident A's nose to try to get him to take his medication. Ms. Bergy is not giving medication to residents for the time being and will be retrained in Gentle Teaching techniques.

I conducted an unannounced site inspection at the Brackenwood AFC home on October 11, 2021. I wore personal protection equipment to protect myself and others. I was met by home manager Cindy Wilkenson who allowed me into the

facility. I observed Resident A at the dining room table during the time of my visit. I spoke with Ms. Wilkenson about the incident that had happened with Resident A. She was not present when the incident happened but did hear about it afterwards. Ms. Wilkenson stated that she had been having regular discussions with the staff regarding any concerns they might have. Direct care worker Ms. Shawn Adams told her about the incident between Ms. Bergy and Resident A. When Ms. Wilkenson confronted Ms. Bergy about it, she admitted that it had happened. Apparently, Resident A was refusing to take his medication and Ms. Bergy plugged Resident A's nose until he took a breath and tried to put his medication in his mouth. Both direct care workers stated that it was the only time it had ever happened. Ms. Wilkenson stated that she responded by contacting the agency's administration and also reported it to the Community Mental Health office of recipient rights. She went on to say that Ms. Bergy is not administering medication any longer and will be retrained on Gentle Teaching techniques. She also contacted Resident A's primary physician to work out an easier way to administer his medication. Resident A's primary physician did provide them with an order to crush his medication and add it to his food or drink.

I spoke with direct care worker Ms. Amanda Bergy by phone on October 25, 2021. I asked her about the incident that had occurred with Resident A. Ms. Bergy stated that she was feeling as if she wasn't getting any help that day from other staff and felt overwhelmed. She acknowledged that when Resident A refused to take his medication, she plugged his nose with her fingers for a second or two. She denied that she stuck the medication in his mouth at that time. Ms. Bergy stated that she "stopped and took a breath" and was more patient with him after that. She was able to get him to take one of his pills. She said that she knew it was wrong for her to physically plug his nose and try to force him to take his medication. Ms. Bergy stated that it had only happened the one time. She has never done that before and never observed another staff person do that. She denied that she was instructed by anyone to do that. Ms. Bergy stated that now that they have a "crush order" for Resident A, it is much easier to give him his medication.

I spoke with direct care worker Ms. Shawn Adams by phone on October 25, 2021. I asked her about the incident she witnessed between Ms. Bergy and Resident A. Ms. Adams stated that she was in the medication room counting medication. Ms. Bergy was in the dining room giving medication to residents. She was having a hard time getting Resident A to take his medication. Ms. Bergy asked for help from Ms. Adams. Ms. Adams explained that they are often able to get Resident A to take his medication if they distract him. Ms. Adams said she was looking for a toy to use to help distract Resident A as she was walking over to them. She observed Ms. Bergy plug Resident A's nose so that he would open his mouth. She said that she could see that this was making Resident A upset. I asked her how she knew that he was upset since he does not use words to express himself. Ms. Adams stated that he was moving his head back and forth vigorously, trying to get his mouth away from her, and pushing her away with his arms. She said that she saw Ms. Bergy plug his nose at least three times. Ms. Adams stated that she told Ms. Bergy that she should

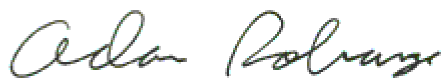
just “write in the book” that he refused his medication instead of trying to force him. There was really nothing else that happened. She had not seen Ms. Bergy ever do that before with Resident A or any other resident. She has not seen any other staff doing it. She has also not seen Ms. Bergy or other staff doing anything with residents that has concerned her before. Ms. Adams stated that, later, she told the home manager Ms. Cindy Wilkenson about what happened.

| APPLICABLE RULE | |
|---|---|
| **R 400.14308** | **Resident behavior interventions prohibitions.** |
| | (2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following:<br>(b) Use any form of physical force other than physical restraint as defined in these rules. |
| **ANALYSIS:** | It was confirmed through this investigation that direct care worker Ms. Amanda Bergy did use a form of physical force when trying to administer medication to Resident A. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

I conducted an exit conference with licensee designee/administrator Mr. Jonathan Harland by phone on October 27, 2021. I told him of the findings of my investigation and gave him the opportunity to ask questions.

## IV. RECOMMENDATION

I recommend no change in the license status.



10/27/2021

Adam Robarge Date
Licensing Consultant

Approved By:

10/27/2021

Jerry Hendrick Date
Area Manager