RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

February 09, 2018

Jennifer Bhaskaran
Alternative Services Inc.
Suite 10
32625 W Seven Mile Rd
Livonia, MI 48152

RE: License #: AS190010545
Investigation #: **2018A0466004**
Bradford Home

Dear Ms. Bhaskaran:

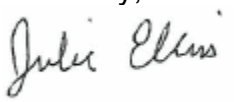
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (517) 284-9720.

Sincerely,



Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS190010545
Investigation #:	2018A0466004
Complaint Receipt Date:	12/13/2017
Investigation Initiation Date:	12/13/2017
Report Due Date:	02/11/2018
Licensee Name:	Alternative Services Inc.
Licensee Address:	Suite 10 32625 W Seven Mile Rd Livonia, MI 48152
Licensee Telephone #:	(248) 471-4880
Administrator:	Jennifer Bhaskaran
Licensee Designee:	Jennifer Bhaskaran
Name of Facility:	Bradford Home
Facility Address:	7757 S Chandler Rd St Johns, MI 48879
Facility Telephone #:	(734) 453-8804
Original Issuance Date:	11/23/1981
License Status:	REGULAR
Effective Date:	06/25/2017
Expiration Date:	06/24/2019
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A was admitted to the hospital as she was not acting like herself and was having difficulty breathing. Resident A has bruising under her left armpit by her breast and X-ray showed a fractured left seventh rib. It's unknown how this occurred as there is no documentation that Resident A had fallen.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/13/2017	Special Investigation Intake 2018A0466004
12/13/2017	Special Investigation Initiated - Letter Complainant
12/13/2017	Contact - Telephone call made to Guardian Ann Bakken from Mid -Michigan Guardianship.
12/14/2017	Contact - Telephone call made interviewed House Manager Bonnie Grandy.
12/14/2017	Contact - Document Sent-Emailed APS worker Thomas Hilla.
12/14/2017	Contact - Telephone call received Phone call from APS worker Thomas Hilla who reported that he reported that he saw Resident A at the hospital and talked with medical personnel.
12/14/2017	Contact - Document Received-Email from APS Worker Thomas Hilla.
12/18/2017	Contact - Telephone call made to APS worker Erin Pung-Cazatt.
12/18/2017	Inspection Completed On-site with APS worker Erin Pung-Caszatt.

01/03/2018	Contact - Telephone call made DCW Amy Romeriez
01/03/2018	Contact - Telephone call made Left message for CMH Case Worker Lindsay Michalik.
01/03/2018	Contact - Telephone call made to APS Worker Thomas Hilla for an update.
01/03/2018	Contact - Telephone call made to DCW Debbie Zelensky, left message.
01/30/2018	Contact- Telephone call made to APS worker Thomas Hilla.
02/05/2018	Contact- Telephone call made to DCW Mindy Mead.
02/05/2018	Exit interview with Jennifer Bhaskaran- left message.
02/09/2018	Contact - Telephone call made to DCW Debbie Zelensky.
02/09/2018	Contact - Telephone call made to CMH Case Worker Lindsay Michalik.

ALLEGATION: Resident A was admitted to the hospital as she was not acting right and was having trouble breathing. Resident A has bruising under her left armpit by her breast and x-ray showed a fractured left seventh rib. It's unknown how this occurred as there is no documentation that Resident A has fallen.

INVESTIGATION:

On December 13, 2017, Complainant reported that Resident A was admitted to the hospital as she was not acting like herself and was having difficulty breathing. Resident A had bruising under her left armpit by her breast and an x-ray showed a fractured left seventh rib. It's unknown how this occurred because there was no documentation that Resident A had fallen or any other explanation for the injury.

On December 13, 2017, I talked with Resident A's guardian, Guardian Ann Bakken from Mid-Michigan Guardianship, who stated that the facility notified her that Resident A was being taken to the hospital, and later that Resident A had been diagnosed with a fractured rib. Ms. Bakken reported that the facility was unaware of how the injury occurred. Ms. Bakken reported that Resident A has received

excellent care in the facility and during her visit at the facility the previous week, Ms. Bakken stated she did not observe any concerns regarding Resident A's care. Ms. Bakken reported that Resident A requires the use of a gait belt to assist with mobility, needs assistance with all aspects of personal care, toileting, grooming, bathing, and feeding, but does not display behavioral challenges. Ms. Bakken stated that Resident A is non-verbal and is not able to answer questions for the purposes of interviewing, but does use vocal sounds such as screams or screeches to express emotions. Ms. Bakken reported that she was not aware of anyone at the facility mistreating or harming Resident A. Ms. Bakken reported that Resident A receives case management services from Community Mental Health and is provided with in-home day programing which means that she is always in the care of the staff at the home.

On December 14, 2017, I talked with house manager DCW Bonnie Grandy over the phone who reported that Resident A was taken to the hospital because direct care workers thought that "she was coming down with something" because Resident A was having difficulty breathing. DCW Grandy reported that Resident A had a bruise on the left side by her rib cage and shortly after the bruise was discovered Resident A started to refuse to stand or walk. DCW Grandy reported that Resident A requires the use of a gait belt due to an unsteady gait, so some days Resident A is not willing to put forth the effort to walk. DCW Grandy reported that Resident A was taken to the hospital by a DCW late Tuesday night December 12, 2017, and admitted early on Wednesday morning December 13, 2017, for a fractured rib and pneumonia. DCW Grandy stated she did not notice any unusual behaviors or indicators from Resident A to indicate that she did not feel well or that she had any type of injury. DCW Grandy denied ever witnessed anyone harm or mistreat Resident A.

I conducted an unannounced investigation on December 18, 2017 with Eaton County DHHS Adult Protective Services (APS) worker Erin Pung-Cazatt. We interviewed DCW Grandy who reported that Resident A typically "screams a lot", but on December 12, 2017, Resident A vocalizations became quieter and a bruise was identified on her left side in the afternoon. DCW Grandy did not have any knowledge about how this injury occurred. DCW Grandy reported that she received a call later in the evening on December 12, 2017, from DCW Amy Ramirez stating that Resident A needed to go the hospital because she was having difficulty breathing.

On December 14, 2017, I interviewed DCW Takeeshe Polite who reported that she did not see any bruises on Resident A but remembered that Resident A was walking funny prior to being hospitalized. DCW Polite never heard or witnessed anyone mistreat or harm Resident A.

On December 14, 2017, I interviewed DCW Kathy Longhorn who reported that she had not seen any bruises on Resident A prior to hospitalization. DCW Longhorn never heard or witnessed anyone mistreat or harm Resident A.

On December 18, 2017, I reviewed Resident A's resident record. Although DCW Grandy reported that staff told her about Resident A's bruise, it was not documented in the *Progress Notes and Shift Observation* log prior to hospitalization. Resident A's record contained a *Community Mental Health Treatment Plan, Data Collection Sheet, Walking Record, Home Activity Checklist, Hygiene Sheet, Daily Body Check Sheet, Health Care Chronical, Assessment for AFC Residents, AFC, Resident Care Agreement*, and doctor orders for Resident A's mattress to be on the floor to decrease risk of falling and maintain independence getting out of bed, use of seatbelt in wheelchair and shower for safety. I reviewed Resident A's *Body Check Sheets* for the month of December 2017, which included the following dates: 12/01/2017, 12/02/2017, 12/03/2017, 12/04/2017, 12/05/2017, 12/06/2017, 12/07/2017, 12/08/2017, 12/09/2017, 12/10/ 2017, 12/11/2017 and 12/12/2017. The only *Body Check Sheet* that documented any bruising on Resident A was the sheet dated December 12, 2017. This sheet documented that there was a "cluster of bruising on front and back of torso" on the same date that Resident A was taken to the hospital due to labored breathing and the large bruise on her rib cage.

On January 05, 2018, I interviewed DCW Amy Ramirez who reported that she had been off two days prior to Resident A being taken to the hospital and noticed that Resident A did not sound like herself right when she arrived on December 12, 2017, for her shift. DCW Ramirez stated Resident A was quieter and less vocal than usual, which was different because Resident A often "squawks and screams" to communicate. DCW Ramirez reported that DCW Liz Rodriguez mentioned to her about Resident A having a bruise, but when DCW Ramirez saw how bad the bruise was she became concerned and called DCW Grandy about 7:30pm. DCW Ramirez reported taking Resident A to the hospital about 10pm. DCW Ramirez reported that Resident A is always escorted by staff to be toileted and that she walks with a gait belt. DCW Ramirez reported that Resident A can be hard to manage with the gait belt due to her being unsteady." DCW Ramirez never heard or witnessed anyone mistreat or harm Resident A.

On January 05, 2018, I interviewed DCW Deb Zelensky who reported being a DCW for eleven years and reported being off work two days prior to Resident A's hospitalization when the changes in Resident A's behavior were noticed. DCW Zelensky reported that she has not witnessed Resident A to be one who bruises easily, falls often or bumps into furniture. DCW Zelensky reported that she did not see the bruising on Resident A prior to the hospitalization. DCW Zelensky never heard or witnessed anyone mistreat or harm Resident A.

On January 08, 2018, I interviewed Lindsay Michalik, case manager at Community Mental Health Authority of Clinton, Eaton, Ingham Counties. Ms. Michalik reported that Resident A's gait is unsteady and requires full care and support from the DCWs. Ms. Michalik reports visiting the facility and being comfortable with the care provided to Resident A. Ms. Michalik remembered the facility reporting to her that Resident A had been sliding down and trying to slide thorough her seatbelt to get out of it in the van. Ms. Michalik reported that Resident A was not successful in getting out of the

seat belt and wondered if the pressure from the seatbelt could have caused the bruising and the broken her rib. Ms. Michalik never witnessed nor heard anyone mistreat Resident A.

On February 9, 2018, I interviewed Ms. Michalik again regarding this behavior. Ms. Michalik reported she was informed by staff members that Resident A was scooting so far down in the seat of the van that the lap belt would be at her arm pit. However, Ms. Michalik was unaware of any instance where Resident A ever became unbuckled from the seat belt in the van or that any injury occurred from this behavior. Ms. Michalik reported Resident A also exhibits scooting to the bottom of the chair when sitting in a recliner so the facility requested to transport Resident A in her wheelchair. Ms. Michalik reported making an occupational therapist referral on August 21, 2017, for Resident A. Ms. Michalik reported that she did not have any further information because no other reports of this behavior have been reported since August 2017.

On February 9, 2018, I talked with DCW Zelensky who reported that Resident A has tried to slide through the seatbelt in the van but has been unsuccessful due to the seatbelt containing both a lap and shoulder harness. No known injuries to Resident A occurred at that time DCW Zelensky reported that the occupational therapist has been out to make adaptions to Resident A's wheelchair because she slides out of her wheelchair even with the lap belt on.

On February 5, 2017, I interviewed DCW Mindy Mead who reported that she never saw any bruises on Resident A prior to hospitalization. DCW Mead learned of the bruises when she came into work on December 12, 2017 just prior to a DCW taking Resident to the hospital. DCW Mead never heard or witnessed anyone mistreat or harm Resident A.

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 December 12, 2017, Resident A had bruising under her left armpit by her breast and was having difficulty breathing. After being taken to the hospital an x-ray showed a fractured left seventh rib and pneumonia. It is unknown how or when the fractured rib occurred as there is no documentation in the resident record that Resident A had fallen or that any other accident occurred. Resident A requires full care from DCWs for toileting, walking, dressing, meals and does not leave the facility without the assistance and supervision of DCWs. Resident A sustained a broken rib while in the care of the facility direct care workers yet no direct care worker knows how the injury occurred. Changes in Resident A behavior displayed as less vocalizations and her refusal to stand and/or walk as well as the large bruise noted on Resident A's Body Check Sheet dated 12/12/2017 should have alerted direct care workers that something was amiss with Resident A's physical well-being. Therefore her personal safety and protection was not attended to at all times.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

On December 14, 2017 and again on December 18, 2018, DCW Grandy stated that she would submit an incident report Resident A's hospitalization. An incident report was never received regarding the hospitalization of Resident A.

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 within 48 hours of any of the following: **(b) Any accident or illness that requires hospitalization.**

ANALYSIS:	An incident report was never received for Resident A's hospitalization on December 12, 2017 despite DCW Grandy reporting that she would complete it and submit it on December 14, 2017, and again on December 18, 2017.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

02/09/2018

_____

Julie Elkins Date
Licensing Consultant

Approved By:

02/09/2018

_____

Dawn N. Timm Date
Area Manager