GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 2, 2021

Jessica Adams
Braintree Management, Inc.
7280 Belding Rd. NE
Rockford, MI 49341

RE: License #: AL340338193
Investigation #: 2022A1029001
Harrison House AFC

Dear Ms. Adams:

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 (231) 922-5309.

Sincerely,

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
(989) 444-9614
Browningj1@michigan.gov

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL340338193
Investigation #:	2022A1029001
Complaint Receipt Date:	10/04/2021
Investigation Initiation Date:	10/04/2021
Report Due Date:	12/03/2021
Licensee Name:	Braintree Management, Inc.
Licensee Address:	7280 Belding Rd. NE Rockford, MI 49341
Licensee Telephone #:	(616) 874-1573
Administrator:	Jessica Adams
Licensee Designee:	Jessica Adams
Name of Facility:	Harrison House AFC
Facility Address:	532 Harrison Avenue Belding, MI 48809
Facility Telephone #:	(616) 244-3443
Original Issuance Date:	04/02/2013
License Status:	REGULAR
Effective Date:	10/01/2021
Expiration Date:	09/30/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED

	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

ALLEGATION(S)

	Violation Established?
Resident A was found deceased at Harrison House on September 29, 2021 and was not found in her room until after 2:00 p.m. and CPR was not given by direct care staff members.	Yes
Additional Findings	Yes

II. METHODOLOGY

10/04/2021	Special Investigation Intake 2022A1029001
10/04/2021	Special Investigation Initiated – Telephone to Ryan Treynor, law enforcement
10/04/2021	Contact - Document Received - Email from Ryan Treynor with 911 transcript and recording.
10/05/2021	Contact - Telephone call made to Medical examiner, Bill Simpson
10/05/2021	Contact - Face to Face with Rosa Cruz, Resident B, Desiree Wyatt, and Amber Sowles at Harrison House
10/21/2021	Contact - Telephone call made to Jason Coniff- left message / text, Guardian A1, Beronica Jones
10/25/2021	Contact - Telephone call made to Jason Coniff. Left a message.
10/25/2021	Contact - Telephone call made to Joanne Withey. Left a message.
10/25/2021	Contact - Telephone call made to Rosa Cruz.
10/25/2021	Contact - Telephone call received Voice mail from Ms. Withey
10/26/2021	Contact - Document Received - Email from Guardian A1
10/27/2021	Contact - Telephone call made to direct care staff member, Joanne Withey

10/27/2021	Contact - Telephone call made to Jason Coniff
10/27/2021	Contact - Telephone call made to Joanne Withey
10/28/2021	Contact - Telephone call made to Mary Reagan, live in direct care staff member.
11/08/2021	Exit Conference with Jessica Adams. Left a message.
11/09/2021	Contact – Telephone call from Timothy Adams. Ms. Adams would like a call on Monday for exit conference.
11/15/2021	Exit conference with Jessica Adams. Left a message.

ALLEGATION:

Resident A was found deceased at Harrison House on September 29, 2021 and was not found in her room until after 2:00 p.m. and CPR was not given by direct care staff members.

INVESTIGATION:

A referral was received on October 4, 2021 via a rejected adult protective services referral stating Resident A was found deceased at Harrison House on September 29, 2021, staff found her and called 911 at 2:55 p.m. Direct care staff members did not provide CPR.

On October 4, 2021, a telephone call was made to Complainant. Complainant was able to confirm that when Resident A was found at Harrison House in her bedroom, there was blood pooling in her face and arms indicating that she was deceased for several hours. According to the complaint, blood pooling occurs in a body when the blood stops pumping and then the blood will pool in parts of the body which looks like bruising and redness. Complainant did not know how many hours she was deceased. During the 911 call, there was a direct care staff member that was not willing to do CPR on Resident A according to Complainant. Direct care staff member Desiree Wyatt informed Complainant she attempted to wake Resident A at 7:00 a.m. but decided to let her sleep in. Resident A has a history of epilepsy and seizures which possibly contributed to her death.

Complainant stated it was clear CPR was not given because direct care staff member Beronica Jones reported it was not done and there was nothing to indicate CPR was given while examining Resident A's body. Resident A was still in bed turned over on her back after the direct care staff member rolled her over. Resident A was not placed on a solid surface for CPR.

Complainant stated there are no concerns that a criminal act occurred causing her death rather it is possible that Resident A had a seizure. There was a pool of dried saliva or vomit on the bed next to Resident A on her pillow.

On October 4, 2021, the police report and call log from 911 was received from Officer Ryan Treynor for review by this consultant. After listening to the 911 call and reviewing the call log, I determined that 911 was called at 2:57 p.m. by direct care staff member Beronica Jones. Ms. Jones stated she just arrived at work at 2:00 p.m. to find Resident A deceased in her bed face down. The 911 operator asked if Resident A was gone and beyond help and Ms. Jones asked for someone to come assist. Ms. Jones said that she called Rosa Cruz and she was told to roll Resident A over to her back. Ms. Jones stated on the phone with 911 that she did not think that anyone checked on her that morning but that "she could be wrong." Ms. Jones was asked by dispatch if there was an automated external defibrillator (AED) on site and Ms. Jones confirmed they did not have one. During the 911 call, Ms. Jones was clear that Resident A was beyond help and CPR was not administered during this call. Although Ms. Jones arrived to work at 2:00p.m., she did not go into Resident A's bedroom until around 2:45p.m. at which time she observed Resident A to be possibly deceased and in need of medical assistance.

According to the report from Belding Police Department authored by Officer Ryan Treynor, when law enforcement and Belding Fire Department arrived, it was discovered the patient was deceased and blood was pooling in Resident A's face and arms. He interviewed Ms. Jones who stated direct care staff member Desiree Wyatt attempted to wake Resident A up but she would not wake up. Since it was not uncommon for her to sleep in, Ms. Wyatt let her stay in bed and proceeded with her day.

On October 5, 2021, a telephone call was made to medical examiner and licensed funeral home director, Bill Simpson. Mr. Simpson stated that from everything he found when he responded to Harrison House and Resident A's history of seizures since she was eight years old, he does not find that her death was trauma related. Mr. Simpson was unable to confirm if she had a seizure. Resident A was found around 2:00 p.m. by direct care staff member, Ms. Jones, at Harrison House. She was found on her bed, face down, with her arm hanging down the left side of the bed. When he arrived at Harrison House, he was informed that Ms. Wyatt asked Resident A if she was going to take her medication at 8:30 a.m. but she did not verbally or physically respond to Ms. Wyatt's prompt so Ms. Wyatt decided to leave and let her sleep.

Mr. Simpson confirmed that Resident A had rigor mortis and livor mortis consistent with someone who has been deceased for several hours. Her primary care physician is Dr. Sheila Gendich in Ionia, Michigan and she signed off on the death certificate. The time of death for Resident A is unknown and he stated he did not want to speculate. When Resident A was found, her nose was flattened down on the mattress. Mr. Simpson stated he found direct care staff at Harrison House, specifically Ms. Jones, responded appropriately and seemed concerned. Ms. Jones reported to him that when she was turned over in the bed, her face was black, cold, and stiff and she was sure Resident A was deceased which is why CPR was not done. Mr. Simpson stated there will not be

an autopsy based on the previous medical history of seizures and Dr. Gendich signing off on the death certificate.

On October 5, 2021, I interviewed direct care staff member Desire Wyatt at Harrison House. Ms. Wyatt confirmed that she was working on September 29, 2021 when Resident A passed away. She was on the morning shift and went to Resident A's room to see if she wanted breakfast and to take her medication. Resident A's bedroom was down the hallway toward the living room and the last bedroom on the right. Ms. Wyatt stated she did not go into the room but knocked while walking by which is typically how they wake the residents up to start the day. Ms. Wyatt stated she then went to the kitchen to start preparing breakfast. After breakfast and morning medications, she worked on some paperwork before starting lunchtime. She also gave the residents lunch time medications and assisted another resident with a shower and personal care. Ms. Wyatt did not go back into Resident's A room or knock on the door after the initial attempt.

Ms. Wyatt stated she was working with direct care staff member, Jason Coniff the morning of September 29, 2021. She stated she does not know if Mr. Coniff went into Resident A's room or not but she remembers hearing him tell another resident to leave Resident A's bedroom around lunch time.

Ms. Wyatt stated that Resident A was very independent so she was not alarmed when she did not see her in the morning. She stated Resident A refuses her medication often and sometimes refuses her meals so this behavior was not unusual on the morning of September 29, 2021. Ms. Wyatt also stated Resident A sometimes slept in until 10:30 a.m., ate breakfast but then skipped lunch. Ms. Wyatt stated Resident A most often refused her liquid medication which was prescribed to prevent seizures. Ms. Wyatt described Resident A refusal for medications as ignoring Ms. Wyatt when she tried to give her medications along with making statements such as "I know you are from Florida so you probably lie," "she did not talk to Democrats," or that she is not going to take her medication "because she is a child of God."

On October 5, 2021, I interviewed home manager, Rosa Cruz. She confirmed Resident A as found around 2:00 p.m. by second shift direct care staff member Desiree Jones who called to notify her. Ms. Cruz stated that the staff will periodically check on the residents while they are cleaning and moving throughout the home, but they do not document room or contact checks.

During this visit, I was able to review the resident record for Resident A. According to her *Assessment Plan for AFC Residents*, it is documented that Resident A "usually follows instruction but sometimes requires several verbal prompts." This is also documented that she requires "multiple verbal reminders" for eating and feeding.

According to the *Health Care Appraisal* dated December 14, 2020 for Resident A had the following diagnosis "Schizoaffective, epilepsy with breakthrough seizures, and mild cognitive impairment."

On October 5, 2021, I interviewed direct care staff member, Amber Sowles. Ms. Sowles stated that she has witnessed Resident A having a seizure in the past. In the mornings, usually one person prepares the breakfast and administering the resident medications. Ms. Sowles described Resident A as “distant” who often stayed in her room to rest.

On October 5, 2021, I interviewed Resident A’s roommate, Resident B. She stated that she and Resident A were not close friends but she has been her roommate for 1.5 years. Resident B stated Resident A went to bed around 8:30 p.m. and would typically sleep in. Resident B stated she did not see Resident A after 8:30 p.m. on September 28, 2021. Resident B woke for the day at 7:00 a.m., got dressed, and went out to the dining room for breakfast. She noticed Resident A was still in bed but since she slept in typically, she did not think anything of it. She did not notice she was deceased since she had her face covered up and she was on her stomach. She did not hear anything during the night that would indicate Resident A was in any trouble or experiencing a medical emergency. Typically, she can hear Resident A if she is having a seizure through the night and she was able to get help for her. She did not hear anything from Resident A while they were asleep the night of September 28, 2021. She would have seizures if she did not take her medications. During the night, sometimes the resident that resides across the hall will use his cell phone to get assistance from the live in staff member, Jason Coniff. Resident B stated Resident A told her in the past that she did not like to take her medications.

Resident B stated there is adequate supervision at Harrison House. When she stays in her room for a while, someone will knock on the door or peek in to make sure she is doing okay or if she needs anything. There has not been a time when she needed assistance at Harrison House and did not receive it from the direct care staff members.

On October 21, 2021, I interviewed direct care staff member, Beronica Jones.
Ms. Jones stated she was speaking with Resident B because she needed help in their room around 2:45 p.m. While in the room, Ms. Jones noticed that Resident A’s hand was dangling. Resident B stated that her roommate, Resident A was in bed all day and that her arm was dangling off her bed. Ms. Jones also called the home manager, Ms. Cruz to inform her that she thought Resident A was deceased because she was faced down and cold. Ms. Cruz told her to roll her over. When Ms. Jones rolled her over, she observed that her face was sunk into her head. Ms. Jones stated 911 responded shortly after.

Ms. Jones stated the last time someone saw Resident A alive was the September 28, 2021 when direct care staff member Joanne Withey and she did a walk through before they left at 9:00 p.m. Resident A and Resident B were both getting into bed at that time and she told them “good night.” To her knowledge, this is the last time anyone spoke to Resident A.

Ms. Jones stated Resident A was typically in the kitchen or outside during the days. Ms. Jones stated Resident A used to enjoy helping to prepare dinner or lunch and typically

wanted to be involved in what was going on. Ms. Jones stated she did not usually get Resident A up for breakfast because she would get herself up around 7:30-8:00 a.m. for breakfast.

Ms. Jones stated Resident A did not have any personal care needs that she would need direct care staff members to complete in the morning. Ms. Jones did not do CPR when she was on the phone with dispatch because she could tell that she was deceased for hours because her neck was black and her face was pushed in.

On October 26, 2021, I received an email from Guardian A1. Guardian A1 stated she was notified by law enforcement of Resident A's death. She stated licensee designee Jessica Adams sent an *AFC Licensing Division - Incident / Accident Report* regarding Resident A's death.

On October 27, 2021, I interviewed direct care staff member Joanne Withey. She stated that she was in the home but not until after Resident A passed away. Ms. Withey stated she started her work shift at 2:00 p.m. working with direct care staff member, Ms. Jones. During the shift, Ms. Jones found Resident A deceased around 2:45 p.m. She went into the room to mop the floor and noticed that she was lying on her stomach face first and her arm was dangling off the bed. She went to nudge her to get up and there was no response. Ms. Withey stated Ms. Jones then called Ms. Cruz and EMS. Ms. Withey stated it was not unusual for Resident A to refuse her medications or to sometimes sleep in. There were times that she would sleep past noon. Typically, if someone is sleeping the direct care staff member would check on them but would let them sleep in.

On October 27, 2021, I interviewed direct care staff member, Mr. Coniff. He was working on September 29, 2021 day shift when Resident A was found deceased. He worked the morning shift with Ms. Wyatt. When he started work, he was making the coffee and drinks. He stated he routinely does most of the morning personal care for Resident C who is in a wheelchair. It takes a while to get him out of his bed and usually takes an hour to get him ready. Mr. Coniff stated Ms. Wyatt woke everyone up and informed him that Resident A was still sleeping so she was going to let her sleep. Mr. Coniff was not sure if she went into Resident A's room because he was in another resident room with the door closed providing personal care. Mr. Coniff stated it was not an uncommon occurrence for Resident A to miss medications, so he was not surprised that she slept through the morning medications and breakfast. Mr. Coniff stated there are some residents that do not get up until around lunch time. After assisting Resident D, Mr. Coniff stated he went upstairs to start cleaning. Typically, Ms. Wyatt would do the downstairs cleaning and he would do the upstairs. There are two doors in between her room which was the last room on the right and their living quarters. He did not hear anything during the night of September 28, 2021 since he was asleep during that time.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Resident A was found deceased between 2:00-3:00 p.m. at Harrison House on September 29, 2021. Ms. Wyatt and Mr. Coniff were working the day shift however neither direct care staff members went into Resident A's room to speak with her during their shift resulting in her not being found deceased until the afternoon shift. According to Resident A's *Assessment Plan for AFC Residents*, she "Usually follows instruction but sometimes several verbal prompts." under eating / feeding and she needs "multiple verbal reminders" for meals. Resident A received one verbal prompt by Ms. Wyatt to wake up for the day but when there was no response, Ms. Wyatt did not make attempts to go into the room or make physical contact with Resident A. Ms. Wyatt stated that she walked by the room without entering but knocked on the door to alert Resident A it was time for breakfast and medications. Although Resident A has a pattern of sleeping in and refusing medications, neither Ms. Wyatt nor Mr. Coniff made contact with Resident A for her to verbally state or physically shake her head in refusal that she did not want to take her medications or eat breakfast. Ms. Wyatt did not hear or see a response from Resident A and took that to mean that she was refusing her meals and medications. Consequently, if either direct care staff members Desiree Wyatt and/or Jason Coniff had provided "several verbal prompts" per Resident A's assessment plan to determine if Resident A was refusing her morning medications, breakfast meal, and lunch meal, medical attention could have been provided sooner to Resident A. Resident A not responding, verbally or physically, to a knock at her bedroom door does not constitute a refusal for medication or meals.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On October 5, 2021, I interviewed direct care staff member Desire Wyatt at Harrison House. She stated that Resident A refuses her medication a few times per week and sometimes her meals. She most often refuses her liquid medication Vimpat Sol 10 mg/ml which is prescribed to prevent her seizures. Ms. Wyatt stated when residents refuse their medications and the medications are already popped out of the bubble packs, the medications are destroyed. They will have another direct care staff member try to give the medications because some residents have other direct care staff members they prefer. Then they will inform the home manager, Ms. Cruz that a medication was refused. At times when Resident A refused her liquid medications, she had a seizure in the afternoon.

On October 5, 2021, I interviewed direct care staff member, Amber Sowles. Ms. Sowles stated that Resident A would often refuse her medications and she wrote refused in the log and let Ms. Cruz know that the resident refused. She did not believe that any health care professionals were contacted by the direct care staff member when a resident refused the medications.

On October 5, 2021, I interviewed Rosa Cruz, whose role is home manager at Harrison House. She stated it was common for Resident A to refuse her medications but that she would have the staff right an “R” in the med log. She denied that there was a procedure in place to notify Resident A’s doctor or pharmacy when this occurred.

On October 21, 2021, I interviewed direct care staff member, Ms. Jones who stated Resident A often missed medications because she did not want to take them. Ms. Jones stated Resident A told direct care staff the reason for refusing medications was because “God told me not too.” Ms. Jones stated if often depended on Resident A’s mood but on average she refused medications five times per week. Ms. Jones stated Resident A did not like to take the liquid that was prescribed for her seizures. On average, she would have a seizure every day if she did not take her medication. When she refused her medication, Ms. Jones stated direct care staff left her alone for a bit and then try again. Ms. Jones stated Resident A preferred her and Ms. Withey and would typically take the medications the second time she was asked. Ms. Jones stated she documented in Resident A’s MAR that she refused the medication. Ms. Jones stated there was no call to Ms. Cruz or to a medical professional advising that Resident A refused the medication.

On October 28, 221, I called Ms. Reagan live-in direct care staff member at Harrison House. Ms. Reagan stated she has been passing medications for the last two months and went through training to do so. Ms. Reagan also stated Resident A refused her medications often and sometimes she would not take them at all. Ms. Reagan confirmed Resident A often refused the liquid medication (Vimpat Sol 10 mg/ml) prescribed for her seizures most often. Ms. Reagan stated there was also a yellow pill

(Olanzapine tab 15 mg ODT) Resident A refused to take and that was typically when she had a seizure during the day. Ms. Reagan stated the process for when a resident refuses medication is to write in the MAR with a “R” for refusal and will let Ms. Cruz know the resident refused.

APPLICABLE RULE	
R 400.15312	**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:	Resident A had a history of refusing her medications at Harrison House. According to interviews with Ms. Wyatt, Ms. Sowles, Ms. Reagan when a resident refuses the medication, the policy is to put a “R” in the MAR for refusal and to notify Ms. Cruz only. Ms. Cruz reported on October 5, 2021 that she does not contact a health care professional when a medication error occurs at Harrison House. According to her medication record, Resident A refused her Vimpat Sol 10mg/ml which is prescribed for her seizures three times during the week (September 21, 23, and 26) preceding her death. There is no documentation that a health care professional was called after Resident A refused her prescribed medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

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

_____11/15/2021_____
Jennifer Browning Date
Licensing Consultant

Approved By:

12/02/2021
_____
Dawn N. Timm Date
Area Manager