GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 10, 2022

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

RE: License #:	AS250278187
Investigation #:	2022A0872037
	Ameno 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 (517) 284-9700.

Sincerely,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250278187
Investigation #:	2022A0872037
Complaint Receipt Date:	05/25/2022
Investigation Initiation Date:	05/26/2022
Report Due Date:	07/24/2022
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:	Ameno Home
Facility Address:	5452 Ameno Lane Swartz Creek, MI 48473-8884
Facility Telephone #:	(810) 655-4215
Original Issuance Date:	10/28/2005
License Status:	REGULAR
Effective Date:	06/19/2022
Expiration Date:	06/18/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 5/22/22, staff placed a hot cup of tea between Resident A's outer leg and wheelchair. It spilled and burned her leg. Wound care scheduled.	Yes

III. METHODOLOGY

05/25/2022	Special Investigation Intake 2022A0872037
05/26/2022	Special Investigation Initiated - Letter
05/26/2022	APS Referral I made an APS complaint via email
06/02/2022	Inspection Completed On-site Unannounced
06/07/2022	Contact - Document Sent I emailed the licensee designee, Judy Dunton, requesting information about this complaint
06/09/2022	Contact - Telephone call made I interviewed Resident A's case manager, Sylvia Golson
06/09/2022	Contact - Telephone call made I interviewed staff Shawntaysha Whitaker
06/09/2022	Contact - Telephone call made I interviewed Resident A
06/09/2022	Exit Conference I conducted an exit conference with the licensee designee, Judith Dunton, via telephone
06/09/2022	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: On 5/22/22, staff placed a hot cup of tea between Resident A's outer leg and wheelchair. It spilled and burned her leg. Wound care scheduled.

INVESTIGATION: I reviewed an Incident/Accident (IR) Report dated 5/22/22 completed by staff Shawntaysha Whitaker. According to the IR, "(Resident A) spilled her hot tea on her left leg. Her leg blistered up and it is the size of a half an arm's length." Resident A was taken to Urgent Care and then referred to Hurley Medical Center's wound clinic for evaluation. The corrective measure taken was, "Do not put cup in client chair with hot liquids even if they request it."

On 6/02/22, I conducted an unannounced onsite inspection of Ameno Home Adult Foster Care facility. I interviewed staff Shelitha Segrest. According to Ms. Segrest, on 5/22/22, she was working at Ameno Home AFC but was out of the facility with another resident while staff Shawntaysha Whitaker was at the facility with the rest of the residents. Ms. Segrest said that when she got back to the facility, Ms. Whitaker was looking for an Incident/Accident Report. Ms. Segrest asked her what had happened, and she said, "(Resident A) spilled her tea on her leg." Ms. Segrest said she went to Resident A who was sitting in a wheelchair with a cold compress on her leg. Ms. Segrest removed the compress and Resident A's pants and thought that the wound/burn looked bad enough that she needed medical attention. Therefore, Ms. Segrest and Ms. Whitaker completed an Incident/Accident Report, contacted the home manager, Dana Kimbrough, and transported Resident A to Urgent Care.

According to Ms. Segrest, Resident A is wheelchair bound and needs assistance with her ADLs. Resident A's wheelchair has a tall cupholder and staff puts her beverages in the cupholder, with a lid and straw, and Resident A is able to bend over and drink out of the straw. On 5/22/22, Resident A's normal wheelchair was being repaired so she was in a different wheelchair that did not have a tall cupholder. When Ms. Segrest asked Ms. Whitaker what had happened, Ms. Whitaker told her that she had secured Resident A's cup of hot tea with a strap but when Resident A bent down to take a drink, she had a muscle spasm and the tea spilled. Resident A was unable to move the cup out of the way and she did receive a burn to her leg for which she is now receiving wound care. Ms. Segrest said that she asked Resident A what happened and Resident A recounted the same version of events as Ms. Whittaker. Ms. Segrest said that Resident A said it was an accident and Ms. Whittaker felt terrible about what happened. Resident A was not present during this inspection, so I was unable to interview her.

On 6/07/22, I emailed the licensee designee, Judy Dunton, requesting information related to this complaint.

On 6/08/22, I reviewed AFC information related to this complaint. Resident A was admitted to Ameno Home AFC on 11/21/17. According to her Health Care Appraisal, she is diagnosed with cerebral palsy and myalgia. She uses a wheelchair for mobility.

According to her Genesee Health System's Individualized Plan of Service (IPOS) dated 12/19/21, she uses a power wheelchair for mobility and requires a 2-person assist or

patient lift. Her IPOS does not address her use of liquids in or out of her wheelchair, and it does not address the cupholder in her wheelchair. The IPOS states, “(Resident A) has difficulty eating her meals due to spasticity and incoordination of movement.” Her IPOS specifies that she uses a long straw for drinking and staff is to set up the supplies she needs for eating. “Staff will stay with (her) during the meal and stay with her to provide assistance and monitoring as needed until she finishes her meal.”

On 6/09/22, I interviewed Resident A’s CMH case manager, Sylvia Golson, via telephone. Ms. Golson confirmed that Resident A was burned by a cup of hot tea that was placed next to her leg in her wheelchair. Ms. Golson also confirmed that Resident A’s normal wheelchair was being repaired which is why she was using a different wheelchair that did not have her usual tall cupholder. According to Ms. Golson, staff did seek appropriate medical attention for Resident A’s wound, and she is still receiving wound care.

On 06/09/22, I interviewed staff Shawntaysha Whitaker via telephone. Ms. Whitaker said that she has worked at Ameno Home since 2016 and has worked with Resident A on numerous occasions. According to Ms. Whitaker, her shift at Ameno home has changed and she does not work with the residents as much as she used to. She said that on 5/22/22, she was working with staff Shelitha Segrest. Ms. Segrest left the facility with another resident, so Ms. Whitaker was in charge of the remaining residents. Resident A asked for a cup of hot tea so after getting Resident A ready and into her wheelchair, Ms. Whitaker brought the tea to Resident A. Ms. Whitaker said that the wheelchair Resident A was in was not her normal wheelchair and there was no cupholder. She asked Resident A if she should still put the cup in the chair, even though it did not have the cupholder and Resident A said, “yes.” Ms. Whitaker said that she secured the cup with the wheelchair strap and went into the kitchen to do dishes. Shortly thereafter, Resident A called out to her. Ms. Whitaker said that when she looked toward Resident A, she could see that she was in distress.

Ms. Whitaker said that she approached Resident A and saw that the cup of tea had spilled and some of the liquid landed on Resident A’s thigh. Ms. Whitaker asked Resident A if she was in pain, and she said no. Ms. Whitaker got a cool, damp towel and a chill pack and placed in on Resident A’s leg. She again asked Resident A if she was in any pain and Resident A told her that it just felt like a sunburn, and it did not really bother her. According to Ms. Whitaker, Ms. Segrest got back to the facility shortly thereafter and they took Resident A into the bathroom to look at her leg. When they took her pants off, they saw that the burn was worse than Ms. Whitaker had thought, and it was beginning to blister. Therefore, they contacted management and transported Resident A to urgent care.

On 06/09/22, I interviewed Resident A via telephone. Resident A confirmed that on 5/22/22, she asked staff Shawntaysha Whitaker for a cup of hot tea. Resident A confirmed that her regular wheelchair was being repaired and she was in a different wheelchair. She said that Ms. Whitaker asked her if it was okay to put the cup in the wheelchair and secure it with the strap and Resident A told her yes. Resident A told me

that she bent down and took one drink out of the cup and then “it spilled and fell on my leg.” According to Resident A, Ms. Whitaker put a cold compress on her leg and checked to make sure she was okay. Once Ms. Whitaker and Ms. Segrest realized the wound was worse than they thought, they transported her to urgent care. Resident A told me that she is still receiving wound care, but she is doing well and will be discharged from wound care soon.

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:	Resident A is diagnosed with cerebral palsy and myalgia, and she uses a motorized wheelchair for mobility. Resident A requires assistance with her ADL’s, and she suffers from incoordination of movements and spasticity. On 5/22/22, Resident A’s regular wheelchair was being repaired so she was using a different wheelchair. Staff Shawntaysha Whitaker put a cup of hot tea on Resident A’s wheelchair, near her leg, strapping it down with a wheelchair strap in an attempt to mobilize it. Resident A leaned down to take a drink and the tea spilled on her leg, causing a blistered burn. I conclude that there is sufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 06/09/22, I conducted an exit conference with the licensee designee, Judith Dunton via telephone. I discussed the results of my investigation and explained which rule violation I am substantiating. Ms. Dunton agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

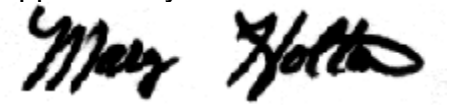
IV. RECOMMENDATION

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

June 10, 2022

Susan Hutchinson Licensing Consultant	Date

Approved By:



June 10, 2022

Mary E. Holton Area Manager	Date