GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 29, 2022

Jessica Kross
Pine Rest Christian Mental Health Services
300 68th Street SE
Grand Rapids, MI 49548

RE: License #: AM410079586
Investigation #: 2022A0340050
Pine Rest Cameron Home

Dear Mrs. Kross:

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 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 (616) 356-0183.

Sincerely,

Rebecca Piccard, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 446-5764

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM410079586
Investigation #:	2022A0340050
Complaint Receipt Date:	08/10/2022
Investigation Initiation Date:	08/10/2022
Report Due Date:	10/09/2022
Licensee Name:	Pine Rest Christian Mental Health Services
Licensee Address:	300 68th Street SE Grand Rapids, MI 49548
Licensee Telephone #:	(616) 455-5000
Administrator:	Candy McKenney
Licensee Designee:	Jessica Kross
Name of Facility:	Pine Rest Cameron Home
Facility Address:	6680 Adrian Avenue SE Grand Rapids, MI 49548-6936
Facility Telephone #:	(616) 281-6392
Original Issuance Date:	02/26/1998
License Status:	REGULAR
Effective Date:	08/13/2022
Expiration Date:	08/12/2024
Capacity:	8
Program Type:	DEVELOPMENTALLY DISABLED AGED

II. ALLEGATION(S)

	Violation Established?
Staff forcefully held down Resident A to administer medication.	Yes
Staff are not protecting Resident A from physical assaults by other residents.	No

III. METHODOLOGY

08/10/2022	Special Investigation Intake 2022A0340050
08/10/2022	Special Investigation Initiated - Telephone
08/10/2022	APS Referral
08/24/2022	Inspection Completed On-site
09/20/2022	Contact – Document Received From Ms. McKenney; termination paperwork for Ms. Huska
09/22/2022	Contact – document received from N180
09/22/2022	Contact – Telephone call made Ms. McKenney
09/27/2022	Contact - Telephone call made Staff Carson Noyes
09/27/2022	Contact - Telephone call made Staff Elisabeth Eisel
09/27/2022	Contact - Telephone call made Staff Katherine Huska
09/28/2022	Exit Conference Designee Jessica Kross

ALLEGATION: Staff forcefully held down Resident A to administer medication.

INVESTIGATION: On August 10, 2022, I received an Incident Report from Home Manager, Mariah Chadwick. It stated that on 8/9/22 Resident A was getting anxious

because Resident B was irritating him, so staff decided to give him a PRN of liquid Ativan. Staff Carson Noyes had the keys to the medication, so he attempted to give it to Resident A. Resident A is nonverbal, so he indicated that he did not want the medication by shaking his head away. Home Manager, Katherine Huska asked Mr. Noyes for the medication so she could attempt to pass it. She told Mr. Noyes that he was going to have to hold his arms down. Mr. Noyes held down Resident A's arms and Ms. Huska put the medication in Resident A's mouth. Later that same day Resident A was anxious again, and again he did not want to take medication. Ms. Huska told staff Elisabeth Eisel to hold his face while she put the liquid Ativan in his mouth with a syringe.

On August 10, 2022, I contacted Administrator Candy McKenney. She was aware of the incidents and staff Katherine Huska has been moved off the Cameron schedule pending the investigation. Ms. McKenney had previously spoken with Ms. Huska and she had reportedly admitted to forcing the medication into Resident A's mouth. Ms. McKenney stated that Ms. Huska took FMLA immediately after but will likely be dismissed for what happened.

On August 24, 2022, I conducted an unannounced home inspection. I am familiar with Resident A, whom I know to be non-verbal. While at the home I saw him sitting in the front room looking out the window. None of the staff working this day were present during either of the alleged incidents.

On September 20, 2022, Ms. McKenney sent me paperwork indicating Ms. Huska's termination from Pine Rest employment.

On September 27, 2022, I interviewed staff Carson Noyes. I asked him to recount the incident he was involved in with Resident A getting PRN liquid Ativan. He said that day Resident B had been shutting the kitchen door and Resident A prefers it to be open, so they were going back and forth with the door. Resident A started having a panic attack and Mr. Noyes knew he had a prescription for liquid Ativan, so he asked Ms. Huska, the home manager, if Resident A needed it. She affirmed the need and when Mr. Noyes attempted to give Resident A the medication, he turned his head away, which was taken as a refusal since Resident A is non-verbal. Mr. Noyes stated that Ms. Huska said, "Gimme that!", referring to the syringe of the Ativan. Ms. Huska then reportedly told Mr. Noyes to hold his arms, which he did, and Ms. Huska squirted the Ativan into his mouth.

I asked Mr. Noyes if he had ever seen Ms. Huska do something like this before and he said he had not. I asked if he was trained to administer medication in this way and he said that he was not, but since Ms. Huska was a manager, he thought that in certain circumstances it was okay. He added that now he knows better. I reiterated with Mr. Noyes that it is never okay for a resident to be forced to take medication no matter the circumstance or who orders it. Mr. Noyes stated that Resident A is no longer given the PRN for his anxiety, and he is now redirected or the other residents are redirected away from him.

On September 27, 2022, I interviewed staff Elisabeth Eisel. I asked Ms. Eisel to recall for me the incident involving Resident A getting a PRN after a fire drill. Ms. Eisel stated that the home had conducted a fire drill in the evening and Resident A had gotten very agitated by it. It was getting to be bedtime and Resident A was still exhibiting behaviors. Home manager Ms. Huska wanted him to calm down and go to bed so she told Ms. Eisel to get some PRN liquid Ativan, since she was holding the medication keys. Resident A was pacing up and down the hall. Ms. Eisel had heard about the PRN method Ms. Huska used previously so she did not question her while she held his face and Ms. Huska squirted the medication in his mouth.

Ms. Eisel stated she usually works third shift, so the residents are usually sleeping for the majority of her shift. Ms. Eisel also stated that she has never had to administer a PRN medication to Resident A before. This was not how she was trained but because Ms. Huska was a manager and she had "held him down" before, Ms. Eisel went along with it. Aside from the incident described above, Ms. Eisel stated she did not know of another incident where Ms. Huska had forced a resident to take medication.

On September 27, 2022, I interviewed staff Katherine Huska. I informed her of the complaint filed regarding the incidents of Resident A getting forced to take his medication. She first admitted that she should not have done what she did, but explained that she was "burned out, tired, and worked a lot of OT". I then asked her to tell me specifically what happened. She stated that Resident B was slamming the door to the kitchen which irritated Resident A who has OCD and likes the door open. Staff tried separating the two of them, but Resident A would not calm down. Mr. Noyes suggested a PRN. Ms. Huska admitted to administering the liquid Ativan, but stated she did not remember who held him. She denied asking Mr. Noyes or anyone else to hold him down. When I asked why someone would report that she did tell him to hold him, she responded stating she did not know.

Ms. Huska said it was the following day that staff conducted a fire drill and Resident A did not want to participate and an anxiety attack followed. He was pacing up and down the hall when Ms. Eisel walked up from behind him and grabbed his arms and Ms. Huska administered the medication. I clarified that Ms. Eisel held his arms and not his face and Ms. Huska then said she did not remember.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's representative, a copy of all of the following resident rights:

	(m) The right to refuse treatment and services, including the taking of medication, and to be made aware of the consequences of that refusal. **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	The allegation was made that on two different occasions, Resident A was forced to take a PRN medication of liquid Ativan after he refused. Staff Carson Noyes stated home manager Katherine Huska told him to hold Resident A's arms down while she administered liquid Ativan into Resident A's mouth. Staff Elisabeth Eisel stated home manager Katherine Huska told her to hold Resident A's face while she administered liquid Ativan into Resident A's mouth. Ms. Huska claimed to not remember who held Resident A while she administered the liquid Ativan. Her account differed from what was reported by staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff are not protecting Resident A from physical assaults by other residents.

INVESTIGATION: On September 22, 2022, Network180 forwarded a complaint stating that Resident A has been the victim of multiple assaults from other residents. It was not known who the perpetrators were, but there is concern that staff are not doing anything about it.

On September 22, 2022, I contacted Ms. McKenney. We discussed the population of the home consisting of residents with aggressive behaviors and a lower cognitive level. In general, they all tend to irritate each other. Resident A has had incidents with Resident B more frequently than others. Both residents are non-verbal and act out physically. Ms. McKenney pointed out that Resident A also tends to become aggressive toward other residents and is not "innocent" as he will hit and bite. There have been recent increases in incident reports (IRs) between Residents A, B and C which were sent for my review. Ms. McKenney stated that Resident A does not have a behavior plan, but Resident B and C do have one. Resident B in particular has more behaviors than the others and is newer to the home. His guardian/mother had requested that all medication be stopped in order to see if his behaviors improved. During this time Resident B's behaviors became much worse. He is now back on his medication and his behavior plan is being reviewed.

Ms. McKenney and I reviewed the most recent IR's over the past two months involving Resident A and B or Resident A and C. The incidents involved behaviors by each resident resulting in staff intervention, including stepping in between residents, and separating the residents from each other, resolving the issues each time. No medical attention was necessary.

On September 27, 2022, I interviewed staff Carson Noyes. I asked him about the behaviors in the home involving Resident A and other residents. He stated that Resident A and Resident B "feed off" each other and probably have more interactions requiring staff intervention than the other residents. Resident B will block Resident A from walking up and down the hallway where he paces. Resident B also throws things when he is exhibiting behaviors. Mr. Noyes did not think it was "targeting" Resident A. It is just coincidental that Resident A is around him and he in turn gets upset and acts out. We discussed the incident with Resident A and B fighting over the kitchen door being open or closed. It's unknown if they know it irritates each other or if they are just doing things which happen to irritate the other.

Mr. Noyes pointed out that Cameron is a "behavior home" and everyone in the home resides there for a reason. If a resident was not safe living in the home, then he feels Pine Rest Administration would change the behavior plan or move the resident to another home, or whatever it takes to keep them safe.

Mr. Noyes stated he has never seen any resident left unprotected. He stated that all of the residents can be "difficult" so to say only one is an innocent victim, would be inaccurate.

On September 27, 2022, I interviewed staff Elisabeth Eisel. I asked her to tell me about any targeting behaviors toward Resident A. Ms. Eisel did not believe anyone to "target" him, but that there are just a lot of behaviors in the home in general because it's a "behavior home". When Resident C gets mad, Ms. Eisel thinks everyone just stays out of her way and if you don't, she would "smack you". I asked Ms. Eisel to describe what she means. She said she doesn't "hit" to cause injury. She will smack with an open hand if they are within reach. Staff ensure everyone is out of her way if she is exhibitng behaviors.

Ms. Eisel stated that Resident B is "attention seeking" and probably does the most acting out. He will hit and throw things. His guardian/mother wanted Resident B off all his medication and it was "a disaster". Resident B is taking his medication again and things have gotten better. When Resident B is acting out staff will take the brunt of his physical aggression. They (staff) will get other residents away from Resident B or redirect Resident B in order to keep everyone safe.

Ms. Eisel added that Resident A will hit and bite if someone is near him while he's exhibiting behaviors. When he is getting agitated staff will intervene between

Resident A and anyone else nearby to ensure everyone remains safe. She stated she did not know of anything unusual or more serious than this.

On September 27, 2022, I interviewed staff Katherine Huska. I asked her about the behaviors in the home involving Resident A. Ms. Huska indicated it is not just one resident acting out. Ms. Huska said that staff do what they can to intervene. I asked if she had concerns regarding Resident A being abused by other residents. Ms. Huska said she did not believe Resident A was being abused or targeted or anything which endangers his safety.

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:	The allegation was made that Resident A is being abused by other residents in the home and staff do nothing about it. Ms. McKenney stated this is a behavior home and the residents act out toward one another. There are three residents named in several IR's that were exhibiting behaviors near the other but she did not feel it was directed or targeted toward Resident A. Due to the residents cognitive level she felt it was coincidental that they happened to be near whomever was having behaviors. Staff intervene to ensure the safety of the residents. Mr. Noyes and Ms. Eisel both stated that they work in a designated "behavior home" and the staff know to intervene to keep others safe when one has a high behavior.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On September 28, 2022, I conducted an exit conference with Designee Jessica Kross. I informed her of the findings of a rule violation. Ms. Kross agreed to a CAP and had no further questions.

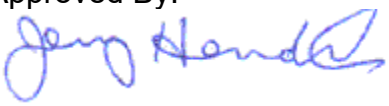
IV. RECOMMENDATION

Upon my receipt of an acceptable Corrective Action Plan, I recommend no change in the current license status.

 September 29, 2022

Rebecca Piccard Date
Licensing Consultant

Approved By:

 September 29, 2022

Jerry Hendrick Date
Area Manager