GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 22, 2022

David Simpson
Northern Lakes Community Mental Health
Suite A
105 Hall Street
Traverse City, MI 49684

RE: License #: AS830263282
Investigation #: 2023A0870013
Seneca Place Home

Dear Mr. Simpson:

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 (231) 922-5309.

Sincerely,

Bruce A. Messer, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 342-4939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS830263282
Investigation #:	2023A0870013
Complaint Receipt Date:	12/02/2022
Investigation Initiation Date:	12/02/2022
Report Due Date:	01/31/2023
Licensee Name:	Northern Lakes Community Mental Health
Licensee Address:	105 Hall Street Traverse City, MI 49684
Licensee Telephone #:	(989) 348-0014
Administrator:	David Simpson
Licensee Designee:	David Simpson
Name of Facility:	Seneca Place Home
Facility Address:	440 Seneca Place Cadillac, MI 49601
Facility Telephone #:	(231) 775-8821
Original Issuance Date:	06/01/2004
License Status:	REGULAR
Effective Date:	01/06/2021
Expiration Date:	01/05/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On November 18, 2022, the AFC staff noticed that Resident A was running a fever of 105 and that his lips and tongue were turning blue. They were instructed to seek medical treatment for Resident A but did not.	Yes

III. METHODOLOGY

12/02/2022	Special Investigation Intake 2023A0870013
12/02/2022	APS Referral This referral was made by Wexford County DHHS, APS.
12/02/2022	Special Investigation Initiated - Telephone Telephone call with APS worker Jesica Kroes.
12/02/2022	Contact - Telephone call made Email to Northern Lakes Community Mental Health Authority, Office of Recipient Rights.
12/07/2022	Inspection Completed On-site Interviews conducted with Licensee Designee Dave Simpson and home manager Melissa Barilka.
12/09/2022	Contact - Telephone call made Interviews conducted with facility staff.
12/12/2022	Contact - Telephone call made Telephone interview with Cadillac Family Physicians.
12/21/2022	Contact - Telephone call made Follow-up interview with home manager Melissa Barilka.
12/22/2022	Exit Conference Completed with Licensee Designee David Simpson.

ALLEGATION: On November 18, 2022, the AFC staff noticed that Resident A was running a fever of 105 and that his lips and tongue were turning blue. They were instructed to seek medical treatment for Resident A but did not.

INVESTIGATION: On December 2, 2022, I spoke, via email, with Brian Newcomb, Director of the Office of Recipient Rights for Northern Lakes Community Mental Health Authority. I provided Mr. Newcomb with the above stated allegation for consideration.

On December 2, 2022, I spoke, by telephone, with Wexford County, Michigan Department of Health and Human Services, Adult Protective Services worker Jesica Kroes. Ms. Kroes stated she has initiated an APS investigation into these allegations, making an on-site visit on November 23, 2022. She stated she had conducted an interview with staff at Cadillac Family Physicians, who confirmed to her that AFC staff were instructed, by CFP, on November 18, 2022, to "take Resident A to the Emergency Room."

On December 7, 2022, I conducted an on-site special investigation at the Seneca Place AFC home. I met with Licensee Designee David Simpson and home manager Melissa Barilka and informed them of the above stated allegation. Ms. Barilka reviewed facility staff documentation from November 18, 2022, concerning Resident A. She noted that on November 18, 2022, at 3:00 p.m. staff member Marla Chase note Resident A "is shivering and his voice is raspy." Resident A's temperature was taken with a reading of 101.1. Facility staff gave Resident A Tylenol and at 3:20 pm called Cadillac Family Physicians, leaving a voicemail. Staff noted that CFP nurse called the facility at 3:43 p.m. and instructed staff to monitor Resident A. Staff notes indicate that Marla Chase took Resident A's temperature at 3:50 p.m. and it registered 101. At 4:00 p.m. staff Tonia Chase recorded that Resident A's temperature was 104. Ms. Tonia Chase contacted Home Manager Melissa Barilka who instructed staff to change the battery in the thermometer, recheck the temperature and call CFP to let them know the temperature was now 104. Notes indicate that staff called CFP at 4:29 p.m. Notes further indicate that staff changed the battery in the thermometer and Resident A's temperature "was still high." Notes state Ms. Barilka instructed staff to purchase a new thermometer and give Resident A a cool bath. A follow-up note indicates that CFP stated that after the new thermometer is used, if the temperature is still 104 "bring him in." A final note states that "about 5:00 p.m.", after Resident A had a bath, his temperature was checked, with the new thermometer, and it was 99.3.

On December 9, 2022, I conducted a telephone interview with staff member Marla Chase. Ms. Chase stated she worked at the facility on November 18, 2022 and was headed home after her shift when she had a call from staff member Tonia Chase, who told her that Resident A had a temperature of 105. Ms. Marla Chase stated Resident A was given Tylenol, facility staff called CFP and Resident A's temperature came down. She stated that CFP instructed staff that "as long as the temperature continues to come down, just monitor (Resident A)." She noted that facility staff were never told that Resident A needed to be "brought in." Ms. Marla Chase also noted that she purchased a new thermometer. She stated that her shift had ended and "other staff may have called CFP afterwards, but she doesn't know who or if anyone did."

On December 9, 2022, I conducted a telephone interview with staff member Tonia Chase. Ms. Tonia Chase stated she worked the afternoon of November 18, 2022, along with Ashley Bergey. She noted that both she and Ms. Bergey spoke with CFP concerning Resident A's temperature and were instructed to take Resident A to the hospital emergency room if his temperature goes above 104. Ms. Tonia Chase stated she or Ms. Bergey took Resident A's temperature "a few times" and it was 104-105. She stated she felt that "no way was it that high." She further stated that shortly after the 104-105 reading, Resident A was administered Tylenol. Ms. Tonia Chase stated that she called Marla Chase, who was at the store, asking her to buy new batteries and a new thermometer. She stated she took Resident A's temperature with the new thermometer, and it read 101. Ms. Tonia Chase stated she continued to take Resident A's temperature throughout the evening, and it was "always lower than 101." She also noted that Ms. Bergey gave Resident A a bath that evening.

On December 9, 2022, I conducted a telephone interview with staff member Ashley Bergey. Ms. Bergey that when she arrived for her afternoon shift on November 18, 2022, she was informed by day shift staff that Resident A was not feeling well. She noted she took Resident A's temperature but does not remember what it read. Ms. Bergey stated that day shift staff told her that they had administered Tylenol to Resident A. She also noted that Ms. Tonia Chase called home manager Melissa Barilka and spoke to CFP. Ms. Bergey stated that Ms. Tonia Chase told her that CFP instructed that if Resident A looks like he is doing ok, just monitor him, but if his temperature get high, call 911. Ms. Bergey stated that she and Ms. Tonia Chase took more temperature readings and "(Resident A's) temperature was 105". She stated she, or Ms. Tonia Chase, called Ms. Barilka and were instructed to get a new thermometer. Ms. Bergey stated that after they received a new thermometer, Resident A's temperature readings were 99. She stated they continued to take Resident A's temperatures through that shift with readings always around 99.

On December 12, 2022, I conducted a telephone interview with Sherry Schuler. Ms. Schuler stated she is a Registered Nurse employed at Cadillac Family Physicians. She reviewed Resident A's record and noted that CFP had "several calls" from Seneca Place AFC on November 18, 2022. Ms. Schuler stated she took the initial call from the home and "the initial reported temperature was not that high." She stated she instructed Seneca Place AFC staff to "monitor" Resident A. Ms. Schuler stated CFP notes indicate after facility staff called back and reported Resident A's temperature had increased. She stated the last record from that day was at 5:18 p.m. and states that Amanda Looney, RN, had instructed Seneca Place staff to "take (Resident A) to the emergency room."

On December 21, 2022, I conducted a follow-up telephone interview with Ms. Barilka. I asked her if there was any staff notation of a call with CFP from 5:18 p.m. on November 18, 2022. After reviewing all documentation, Ms. Barilka stated there were no staff notations of the call, but she was able to find documentation, received from CFP, which state that at 5:18 p.m. CFP nurse Amanda Looney called the home

stating, “Tonia at Seneca notified.” Ms. Barilka stated the note does not comment on what Tonia was notified of, nor as stated above, did Tonia or any other staff document what the notification at 5:18 was regarding.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.** **(4) In case of an accident or sudden adverse change in a resident’s physical condition or adjustment, a group home shall obtain needed care immediately.**
ANALYSIS:	Nursing staff from Cadillac Family Physicians state that they instructed Seneca Place AFC staff to seek medical attention after reports that Resident A’s temperature was above normal. Seneca Place AFC staff did not take Resident A to his physicians’ office or the hospital emergency room as instructed by his physician’s office, Cadillac Family Physicians. The facility staff failed to follow the instructions and recommendation to seek medical attention for Resident A. The facility staff failed to obtain needed care immediately following the noted change in Resident A’s physical condition.
CONCLUSION:	**VIOLATION ESTABLISHED**

On December 22, 2022, I conducted an exit conference with Licensee Designee David Simpson. I informed Mr. Simpson of my findings as noted above. He stated he understood, and had no further information to provide concerning this special investigation. Mr. Simpson noted he would develop and submit a corrective action plan to address the established rule noncompliance.

IV. RECOMMENDATION

I recommend, contingent upon the submission of an acceptable corrective action plan, that the status of the license remain unchanged.

December 22, 2022

Bruce A. Messer Date
Licensing Consultant

Approved By:

December 22, 2022

Jerry Hendrick Date
Area Manager