GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 6, 2023

Carolyn Bruning
Northeast Michigan CMH Authority
400 Johnson Street
Alpena, MI 49707

RE: License #: AS040095845
Investigation #: 2023A0360014
Princeton Home

Dear Ms. Bruning:

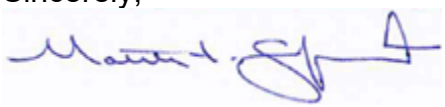
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (866) 865-0006.

Sincerely,



Matthew Soderquist, Licensing Consultant
Bureau of Community and Health Systems
Ste 3
931 S Otsego Ave
Gaylord, MI 49735
(989) 370-8320

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS040095845
Investigation #:	2023A0360014
Complaint Receipt Date:	01/09/2023
Investigation Initiation Date:	01/09/2023
Report Due Date:	03/10/2023
Licensee Name:	Northeast Michigan CMH Authority
Licensee Address:	400 Johnson Street Alpena, MI 49707
Licensee Telephone #:	(989) 358-7603
Administrator:	Nicole Kaiser
Licensee Designee:	Carolyn Bruning
Name of Facility:	Princeton Home
Facility Address:	215 Princeton Alpena, MI 49707
Facility Telephone #:	(989) 356-9318
Original Issuance Date:	06/26/2001
License Status:	REGULAR
Effective Date:	03/06/2022
Expiration Date:	03/05/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A was not administered oxygen as prescribed and her oxygen saturation fell to 83%.	Yes

III. METHODOLOGY

01/09/2023	Special Investigation Intake 2023A0360014
01/09/2023	Special Investigation Initiated - Telephone Ruth Hewitt NEMCMH ORR
01/12/2023	Contact - Face to Face Ruth Hewitt NEMCMH ORR, DCS Melody Barker, DCS Elizabeth Horwitz
01/12/2023	Inspection Completed On-site DCS Andrea Smith, Resident A
03/06/2023	APS referral
03/06/2023	Exit Conference With Licensee Designee Carolyn Bruning

ALLEGATION: Resident A was not administered oxygen as prescribed and her oxygen saturation fell to 83%.

INVESTIGATION: On 1/09/2023 I was assigned a complaint from the LARA online complaint system.

On 1/09/2023 I contacted Ruth Hewitt with Northeast Michigan Community Mental Health office of recipient rights. Ms. Hewitt stated that she received an incident report dated 12/24/2022 in which Resident A's Oxygen concentrator was malfunctioning and the staff turned it off for approximately two hours and when Resident A's oxygen saturation was measured during the shift change at 8:00 a.m. it was at 83%.

On 1/12/2023 I conducted a joint interview with Ms. Hewitt of direct care staff Melody Barker. Ms. Barker stated on 12/24/2022 she was working the overnight shift and the other direct care staff; Elizabeth Horwitz told her that Resident A's oxygen concentrator was not working properly. She stated this was at about 5:00 a.m. She stated the machine was making a "weird noise", so they turned it off and turned it back on. She stated the machine was still making a beeping noise, so they shut the machine off at about 6:00 a.m. and did 30-minute checks of Resident A. She stated

they did not check Resident A's oxygen saturation levels during the 30-minute checks. She stated they documented in the night shift notes that they had shut off the machine and asked the morning shift to relay to the home supervisor that it was malfunctioning. I then interviewed direct care staff Elizabeth Horwitz. Ms. Horwitz stated on 12/24/2022 at about 6:00 a.m. she checked Resident A's Oxygen concentrator because Resident A had been removing her nasal cannula all night and Ms. Horwitz stated she kept putting it back on her. She stated at 6:00 a.m. the machine was making a beeping noise which sometimes means the water needs to be filled. She stated she shut the machine off, filled the water and turned it back on but it was still making a weird noise and beeping. She stated she noticed there was no air flow through the nasal cannula. She stated Ms. Barker then shut the machine off, wrote a note and then must have forgot to update the morning shift staff. She stated they did not measure Resident A's oxygen saturation level before they left their shift. She stated she thought Resident A's health care program indicated that Resident A could be off of her oxygen for up to two hours.

On 1/12/2023 rights officer Ruth Hewitt provided me with a copy of Resident A's physician orders. The physician orders dated 4/21/22 documented Resident A is to receive Oxygen 2-4 L/min via nasal cannula or 5 L/min via face mask to maintain SaO2 above 94%. She also provided a copy of an incident report dated 12/24/2022 at 8:00 a.m. written by direct care staff Andrea Smith which documented, "Staff noticed [Resident A's] oxygen machine was not on. Staff turned it on, and it started making noise. Staff took Carol's oxygen level, and it was 85%. Staff imminently got one of her tanks and hooked her up. Staff called Care Linc and someone came out with a new machine."

On 1/12/2023 I conducted an unannounced onsite inspection at the facility. Resident A was in bed and was non-verbal and unable to be interviewed. Direct care staff Andrea Smith stated when she came into work on 12/24/2022 at 8:00 a.m. she noticed the oxygen concentrator was off. She stated the night shift staff did not tell her that the machine was not working. She stated she tried to turn it on, and it was making a weird noise. She stated she then measured Resident A's oxygen saturation which was at 83%. She stated she immediately connected a portable tank to Resident A's nasal cannula and started her on a flow of Oxygen. She stated she continued to measure Resident A's oxygen level and it returned to 96% shortly after connecting to the portable oxygen tank. She stated she then contacted Care Linc who sent out a new Oxygen concentrator.

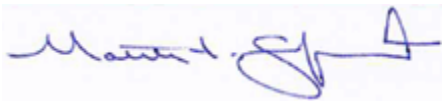
APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following:

	(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.
ANALYSIS:	The complaint alleged Resident A was not administered oxygen as prescribed and her oxygen saturation fell to 83% On 12/24/2022 Resident A's oxygen concentrator malfunctioned. The direct care staff turned the machine off and did not administer Resident A oxygen for approximately two hours until another direct care staff administered Resident A oxygen through a portable tank. Resident A's physicians orders stated that she is to be administered oxygen at a rate of 2-4 L/min via nasal cannula to maintain an oxygen saturation above 94%. Resident A's oxygen saturation was at 83% on the morning of 12/24/2022. There is a preponderance of evidence that Resident A's health care needs were not provided as ordered.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 03/06/2023 I conducted an exit conference with licensee designee Carolyn Bruning. Ms. Bruning stated she concurred with the findings and would submit a corrective action plan for approval.

IV. RECOMMENDATION

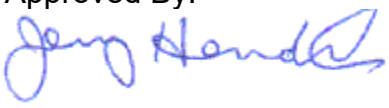
Upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.



03/06/2023

Matthew Soderquist, Licensing Consultant Date

Approved By:



03/06/2023

Jerry Hendrick, Area Manager Date