GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 11, 2023

Susan Wilson
Kennedy House
1623 High Street
Traverse City, MI 49684

RE: License #: AS280285261
Investigation #: 2023A0009022
Kennedy House

Dear Ms. Wilson:

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 the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- A specific time frame for the 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,

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 350-0939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS280285261
Investigation #:	2023A0009022
Complaint Receipt Date:	04/18/2023
Investigation Initiation Date:	04/21/2023
Report Due Date:	05/18/2023
Licensee Name:	Kennedy House
Licensee Address:	1623 High Street Traverse City, MI 49684
Licensee Telephone #:	(231) 884-4916
Administrator:	Susan Wilson
Licensee Designee:	Susan Wilson
Name of Facility:	Kennedy House
Facility Address:	1623 High Street Traverse City, MI 49684
Facility Telephone #:	(231) 884-4916
Original Issuance Date:	12/11/2006
License Status:	REGULAR
Effective Date:	12/21/2021
Expiration Date:	12/20/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Facility staff were not trained to care for someone with Resident A's condition including her dementia. The staff did not recognize when Resident A experienced toxicity/overdose on her medication.	No
The guardian was not notified immediately on April 6, 2023 when Emergency Medical Services were called to care for Resident A. She was not given written notice of Resident A's hospitalization.	Yes

III. METHODOLOGY

04/18/2023	Special Investigation Intake 2023A0009022
04/21/2023	Special Investigation Initiated - On Site Interview with direct care worker Layla Sizemore and licensee designee Susan Wilson
04/26/2023	Contact – Telephone call received from Resident A's Guardian
05/04/2023	Contact – Telephone call received from Community Mental Health (CMH) caseworker Maggie Henning
05/05/2023	Contact – Document (email) sent to licensing consultant Bruce Messer
05/05/2023	Contact – Document (email) received from licensing consultant Bruce Messer
05/05/2023	Contact – Telephone call made to licensee designee Susan Wilson
05/08/2023	Contact – Telephone call received from CMH supervisor Darlene Buchner
05/09/2023	Contact – Telephone call received from CMH caseworker Martha Falk
05/09/2023	Contact – Telephone call made to CMH nurse Jeffrey Kaiser, left message
05/09/2023	Exit conference with licensee designee Susan Wilson

05/10/2023	Contact – Telephone call received from CMH nurse Jeffrey Kaiser

ALLEGATION: Facility staff were not trained to care for someone with Resident A's condition including her dementia. The staff did not recognize when Resident A experienced toxicity/overdose on her medication.

INVESTIGATION: I made an unannounced site visit at the Kennedy House adult foster care home on April 21, 2023. I spoke with direct care worker Layla Sizemore at that time. Ms. Sizemore reported that she had worked at the facility since February of 2023. She said that she had worked with Resident A quite a bit during her time there which was only about a month or so. I asked her about her experiences working with Resident A. Ms. Sizemore reported that Resident A had tried to hit her on several occasions. I asked her why she thought that Resident A would do that. Ms. Sizemore replied it was because they were supposed to ask Resident A each hour to use the bathroom because she would not on her own. If they did not do that, Resident A would just sit in her own urine. Resident A rarely wanted to use the toilet, though, and would often try to fight her. Ms. Sizemore said that she would gently encourage and direct Resident A to use the bathroom while trying not to be hit by her.

The licensee designee, Susan Wilson, showed up to the facility at this time. I told her that I had received a complaint regarding Resident A. Ms. Wilson stated that Resident A had been somewhat aggressive when she had first been placed with them but that it has been getting worse lately. Resident A was prescribed an as-needed dose of Ativan to help with these episodes. As the behavior worsened, Ms. Wilson asked that it be a scheduled dose to help decrease Resident A's aggressiveness. Resident A's behavior did improve after she was prescribed the Ativan once a day. There were no issues until April 6, 2023, when Resident A had trouble getting up from the dining room table. Resident A seemed to lose strength at that time so Ms. Sizemore jumped in to assist her. The chair she had been sitting in slid away in the process. At that point, Resident A started trying to sit back down but the chair was no longer beneath her. Ms. Sizemore could not lift her but was able to help her gently to the floor so that Resident A would not be hurt. Ms. Wilson said that she was also present but that the two of them were not able to get her off the floor. Ms. Wilson said that she felt that the safest course of action was for her to call 911 and get their assistance with Resident A. Emergency Medical Services (EMS) did arrive shortly thereafter and rendered assistance. They helped her get Resident A off the floor and checked her out while they were there. They took her vitals at that time and deemed that she was medically okay. Resident A then went to the bathroom and seemed okay for the rest of the night.

The next day, on April 7, 2023, Resident A came out of the bathroom and couldn't hold herself up. Ms. Wilson said that she saw her starting to slump over and went quickly over to her to keep her from falling over. Resident A said that she was feeling weak. Ms. Wilson said that she immediately called 911 while holding

Resident A. As soon as she was sure that EMS was on their way, she called the guardian and told her what had happened and that she had just called 911. Ms. Wilson showed me on her phone's call history that she had called Resident A's guardian at that time. I noted that her phone call history showed that a call lasting 1 minute and 15 seconds had occurred on April 7, 2023, to the guardian's phone number at 10:04 a.m. The phone call history also showed that she had called or attempted to call the guardian four other times later that day. One call to the guardian's phone number at 4:40 p.m. had lasted 2 minutes and 22 seconds.

Ms. Wilson said that with someone who has dementia, every day is different and you have to be ready for whatever mental state they are in on any given day. She said that she understood that she and her staff need to supervise someone with dementia very closely and make sure that all their immediate needs are met. Ms. Wilson said that she also works with Community Mental Health (CMH) to make sure that all Resident A's needs are met. For example, CMH had directed them to prompt Resident A in using the bathroom each hour. Because this was causing Resident A to become angry, the CMH caseworker and guardian had agreed to modify this to once every two hours. She said that was an example of all three of them working together in making a decision that helped meet Resident A's needs. Ms. Wilson said that she would always follow the direction of the various CMH personnel involved in how Resident A should be cared for.

I asked for Resident A's written assessment. Ms. Wilson provided me with Resident A's Annual Clinical Assessment from CMH dated October 14, 2022. She said this was the last written assessment she had received from CMH. She also provided me with her own written assessment (BCAL-3265) for Resident A.

I reviewed Resident A's Annual Clinical Assessment from CMH dated October 14, 2022. It indicated that Resident A did not have a Behavior Plan. It reported that, *'(Resident A) continues to require reminders to change her briefs as well as use the bathroom on a regular basis. Staff provide her showers by washing her body and hair. The staff complete her meal prep, laundry, housekeeping, shopping, and medication management. (Resident A) has a conservator for her finances. She needs assistance in the community due to mobility, dementia, and judgement/vulnerability. She needs 24-hour staffing for safety and for assistance with personal care*." It further reported, *"(Resident A) requires one-on-one assistance with showering. The staff wash her body and hair for her because she does not wash properly. The staff complete her laundry, shopping, medications, food preparation, and her guardian handles finances. Staff prompt (Resident A) to change her brief and have to check or she will wear the same soiled brief all day. She is urine incontinent. (Resident A) has a timer for each hour to go to the bathroom. The staff prompt (Resident A) to wear new clothes or she will not change. They also have to help her pull up her pants after she uses the bathroom.'* It also indicated, *'(Resident A) is monitored by her PCP. The home makes healthy meals and snacks. She does have the occasional fall and uses a walker to prevent falls. She used a wheelchair in the community as she has fallen several times this*

year on outings. She does see a psychiatrist at Pine Rest. She has ongoing confusion due to her dementia.' The assessment also reported, *'She moved to Kennedy House Zimmerman Road and flourished with the warm staff support and social interaction. (Resident A) transitioned to the Kennedy House on High Street in October of 2017. She was experiencing dizziness and unsteady gait and the High Street home is more accessible (no stairs) than Zimmerman Road. (Resident A) stated she is very happy at High Street.'*

I also reviewed the Written Assessment (BCAL-3265) completed by Susan Wilson dated November 15, 2022. It indicated that Resident A requires prompts and full or partial assistance when in the community, with toileting, bathing, grooming, some assistance with dressing, personal hygiene and when using the stairs. The assessment indicated that Resident A used a walker and a wheelchair outside of the home.

I received a phone call from Resident A's guardian on April 26, 2023. She said that she was most concerned that Resident A had fallen on April 6, 2023 and she was never contacted by Ms. Wilson. She said that the first she knew that her aunt was having a problem was when she was contacted the next day and told that Resident A had fallen and that EMS had been called. Ms. Wilson told her that Resident A was in a chair and that she was helping to hold her up. Resident A's guardian said that she immediately went to the hospital. The hospital personnel told her that her aunt's blood pressure and heart rate were low. They believed she might have had a stroke but then determined that she was having a reaction to her Ativan. Resident A's guardian said that she was concerned that the staff at Kennedy House did not recognize the signs of medication toxicity or overdose that Resident A was experiencing. The Ativan had recently been changed by Resident A's psychiatrist from an as-needed to a scheduled medication. They had all agreed to this change to help with Resident A's behavior and the CMH nurse had felt it was okay. Ms. Wilson had expressed concern about Resident A's behavior because she was attacking staff. Ms. Wilson said that she might have to do a "30-day eviction" if they could not get Resident A's aggressive behavior under control. I talked with Resident A's guardian about the fact that Ms. Wilson did not contact her after the April 6 visit from EMS to the home. I explained to her that the incident as described to me did not necessarily require Ms. Wilson to contact her since Resident A was not hospitalized. I said that the April 7 hospitalization did require her to be contacted by telephone immediately and with a written report within 48 hours. Resident A's guardian denied that she had received a written report within that time-frame or even afterwards. She said that she did not believe that CMH received a written report about the hospitalization either.

I received a phone call from CMH caseworker Maggie Henning on May 4, 2023. She said that she had been Resident A's caseworker until just recently. She worked with her for three and a half years. Most of that time, Resident A resided at the Kennedy House. I asked her about Resident A's diagnosis of dementia. She said that she did understand that Resident A has dementia. Ms. Henning believed that

Resident A's outbursts were related to her confusion which is from the dementia. I asked her about the fact that staff might not be trained at the home for dementia and whether she still felt the home was able to adequately care for Resident A. She said that she did not know of any Specialized Residential Services (SRS) homes which are specifically designated as dementia homes. There are many CMH clients with dementia who are in homes that are not specially designated as dementia homes. Ms. Henning said that she always felt that an SRS home was the best option for someone like Resident A because the ratio there was usually a 1:3 staff to resident ratio rather than a nursing home which might have a 1:20 ratio or even a 1:40 ratio. The Kennedy House provides a home-like, nurturing environment. She went on to say that an SRS home is the highest level of care that CMH provides. Ms. Henning said that she had been the one to recommend Kennedy House because there are no stairs there and she believed that the staff provided good care to residents there. Ms. Henning believed that it was an appropriate placement for Resident A knowing her needs and knowing the competence of the staff there. She had always felt that Resident A was well-cared for there. She believed that they provided close supervision and cared for Resident A's specific needs. Ms. Henning said that she never had any problems with the Kennedy House and that included their care of Resident A. I asked Ms. Henning about Resident A's Annual Clinical Assessment which she had created in October of 2022. I believed this to be her last written assessment from CMH. Ms. Henning agreed that she was familiar with it. I asked her if she felt that Ms. Wilson and other staff at the Kennedy House had followed the written assessment. She said yes, Resident A was always clean, they showered her on a regular basis and provided other care. They used prompts to remind her to do her own care needs for those things that she is able to do on her own or with partial assistance. They provided for all her daily care including medication administration and food preparation. She said that she knew that the Kennedy House had struggled with Resident A's sometimes difficult behavior but they never gave her a 30-day eviction notice or dropped her off at the emergency room like some homes do when they are frustrated with a resident.

I received a phone call from CMH supervisor Darlene Buchner on May 8, 2023. I asked her about Resident A's diagnosis of dementia and the staff at the Kennedy House not necessarily being trained in dementia. Ms. Buchner stated that she knew that Resident A had experienced more dementia as time went on with it becoming more of an issue lately. She said that she believed that a home could care for a person with dementia without being specifically designated as a dementia home. She said that they have many residents who reside in their homes who have dementia and many who are on hospice. The care should be sufficient if staff are keeping them safe and focusing on behavior. Ms. Buchner denied that she knew of anything in the Mental Health Code regarding staff being specifically trained in dementia to care for someone with a diagnosis of dementia. Because of Resident A's increasing behavior issues, CMH was in the process of asking for a Behavior Support Plan for Resident A which would have addressed her needs more specifically and given the home any tools they needed to care for her. Ms. Buchner stated that Resident A's needs could better be met in an SRS home because the

staff to resident ratio is so much better than other facilities. She said that she felt that residents got better in SRS homes because of the staff interaction that was able to happen in these homes.

I spoke with CMH caseworker Martha Falk by phone on May 9, 2023. She said that she had only been Resident A's caseworker since February of 2023. Ms. Henning had worked with Resident A during the years before that. She said that she was aware of what was in Resident A's written assessment and the care that the home was expected to provide for her. She said that she believed the home had provided care as outlined in the written assessment. Ms. Falk said that Resident A always seemed well-cared for when she saw her at the home. She never smelled of urine which is sometimes apparent for residents who experience incontinence. The staff helped Resident A with showering and other care needs. They completed her laundry, did her shopping, gave her medication and performed food preparation. Staff also prompted her every hour to try to use the bathroom or change her briefs. This later changed to once every two hours because they believed she was becoming frustrated about the prompts being so often. I asked her about Resident A having an adverse drug reaction to her Ativan. Ms. Falk replied that they had met and discussed changing her as-needed Ativan to a scheduled dose. Resident A's guardian was involved in that discussion and agreed to it. It was Resident A's doctor who changed the prescription. Resident A then had an allergic reaction to the medication. She felt that the staff at the home had done the best they could with Resident A given her increasing dementia and aggressive behavior. Resident A's needs were being met at the home and she always seemed well-cared for there.

I spoke with CMH nurse Jeffrey Kaiser by phone on May 10, 2023. He said that he has met with Resident A monthly since 2018. She has resided at the Kennedy House for most of that time. He said that she absolutely seemed well-cared for. He would only be there for a couple of hours each visit but he observed staff interaction with her during that time. The staff were always appropriate with her and it was apparent that they cared for her. Resident A was always quite happy. She always seemed clean and never smelled of urine. Mr. Kaiser said that he was mostly there to help Resident A become stronger to prevent fall risks. He also educated the staff about being there to make sure she did not fall. Mr. Kaiser said that he observed that the staff were always aware of where she was and would always observe her when she walked from her room to the dining room or her room to the bathroom. They would often stand right next to her as she walked. Mr. Kaiser said that he was not that involved with Resident A's medication. Her medication was "stable" so there was no need for him to be that involved. He did know that her Ativan went from being an as-needed medication to a scheduled medication. It is not unusual for this to happen. I asked him about Resident A having an allergic reaction or otherwise adverse reaction to her Ativan prescription. He said that he did hear about the details of that after it happened. He said that he felt that the staff had reacted appropriately to the situation. They had responded immediately after seeing that Resident A was experiencing a side effect. Mr. Kaiser said that he did feel that staff there knew what to look for in terms of medication side effects. He said that he

believed that he had seen medication side effects information sheets located in the medication logs to educate staff.

APPLICABLE RULE	
R 400.14303	**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's medication was adjusted from being an as-needed medication to a scheduled medication by her doctor. On April 6, 2023, Resident A had difficulty getting up from the dining room table by herself. A staff stepped in quickly and helped her slowly to the floor because the chair had slid away in the process. EMS was called at that time who helped get Resident A up off the floor and checked her out medically. They did not believe that she needed further medical treatment at that time. Resident A experienced weakness again the next day and staff were nearby to make sure she did not fall. EMS was again called immediately and Resident A was taken to the hospital at that time. It was determined that she had an adverse reaction to the increased dosage of her medication at that time. In each instance, staff were nearby to assist Resident A and EMS was called on each occasion. It was confirmed through this investigation that the licensee did provide supervision, protection and care to Resident A and as specified in her written assessment plan. I reviewed the CMH written assessment as well as the home's written assessment for Resident A. According to the caseworkers, supervisor and nurse involved, Resident A was receiving care as specified in the written assessment plan.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: The guardian was not notified immediately on April 6, 2023 when Emergency Medical Services were called to care for Resident A. She was not given written notice of Resident A's hospitalization.

INVESTIGATION: On April 21, 2023, licensee designee Susan Wilson discussed the incident on April 6, 2023, when Resident A had trouble sitting in her chair and direct care worker Layla Sizemore helped her to the ground. EMS had responded to the home at that time. They helped Resident A get off the floor and checked her out at that time. They deemed that she was okay medically and did not feel that she

needed to go the hospital. I asked Ms. Wilson if she had notified the guardian or community mental health at that time. She said that she had not because they had not believed it was a medical issue at that point. Resident A had seemed okay after EMS arrived and they had not found anything wrong with her. They did not believe she needed to go to the hospital. Resident A had not been hurt in any way because direct care worker Layla Sizemore had helped her to the floor and was successful in making sure Resident A was not hurt. She had not believed that she had an obligation to report it to Resident A's guardian at that time.

After the April 7, 2023 incident, as soon as she was sure that EMS was on their way, she called the guardian and told her what had happened. She told her that she had just called 911. Ms. Wilson showed me on her phone's call history that she had called Resident A's guardian at that time. I noted that her phone call history showed that a call lasting 1 minute and 15 seconds had occurred on April 7, 2023, to the guardian's phone number at 10:04 a.m. The phone call history also showed that she had called or attempted to call the guardian four other times later that day. One call to the guardian's phone number at 4:40 p.m. had lasted 2 minutes and 22 seconds.

I received a phone call from Resident A's guardian on April 26, 2023. She said that she was most concerned that Resident A had fallen on April 6, 2023 and she was never contacted by Ms. Wilson. She said that the first she knew that her aunt was having a problem was when she was contacted the next day to be told that Resident A had fallen and that EMS had been called. I talked with Resident A's guardian about the fact that Ms. Wilson did not contact her after the April 6 visit from EMS to the home. I told her that I did not feel that the incident as described to me necessarily required Ms. Wilson to contact her since Resident A was not hospitalized. I agreed that it might have been a good idea for Ms. Wilson to contact her at that time. I said that the April 7 hospitalization did require for her to be contacted by telephone immediately and with a written report within 48 hours. Resident A's guardian denied that she had received a written report within that time-frame or even afterwards. She said that she did not believe that CMH received a written report about the hospitalization either.

I spoke with licensee designee Susan Wilson by phone on May 5, 2023. I asked if she had sent a written report to the guardian, CMH or to her licensing consultant after Resident A's hospitalization. She said that she had sent one to her licensing consultant, Bruce Messer, and the CMH office of recipient rights. She denied that she sent it to the guardian believing that the recipient rights officer would do that. I also talked to her about the fact that although it might not have been a requirement for her to report the April 6 incident to Resident A's guardian, it would have been a good idea.

I contacted licensing consultant Bruce Messer by email on May 5, 2023. I asked if he had received a written report from Susan Wilson on or in the days after April 7, 2023, regarding Resident A being hospitalized. He replied by email that he did not see that he had received a report from Ms. Wilson regarding Resident A on April 7 or anytime after that.

I spoke with CMH supervisor Darlene Buchner by phone on May 8, 2023. I asked her if they had received a written report regarding Resident A's hospitalization on April 7, 2023, or in the days since then. She consulted her database but did not see that CMH had received a written report from Ms. Wilson regarding Resident A since that date.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: (a) The death of a resident. (b) Any accident or illness that requires hospitalization. (c) Incidents that involve any of the following: (i) Displays of serious hostility. (ii) Hospitalization. (iii) Attempts at self-inflicted harm or harm to others. (iv) Instances of destruction to property. (d) Incidents that involve the arrest or conviction of a resident as required pursuant to the provisions of section 1403 of Act No. 322 of the Public Acts of 1988.
ANALYSIS:	It was confirmed through this investigation that the licensee did not provide a written report to Resident A's designated representative within 48 hours of her hospitalization. There was also no record that she had sent a written report to Resident A's responsible agency, CMH, or to the adult foster care licensing division.
CONCLUSION:	**VIOLATION ESTABLISHED**

I conducted an exit conference with licensee designee Susan Wilson by phone on May 9, 2023. I told her of the findings of my investigation and gave her the opportunity to ask questions.

IV. RECOMMENDATION

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

05/11/2023

Adam Robarge Date
Licensing Consultant

Approved By:

05/11/2023

Jerry Hendrick Date
Area Manager