GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 30, 2023

Paula Barnes
Central State Community Services, Inc.
Suite 201
2603 W Wackerly Rd
Midland, MI 48640

RE: License #:	AS090010229
Investigation #:	2023A0123038
	Willow House

Dear Ms. Barnes:

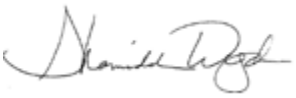
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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) 643-7960.

Sincerely,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS090010229
Investigation #:	2023A0123038
Complaint Receipt Date:	04/27/2023
Investigation Initiation Date:	04/28/2023
Report Due Date:	06/26/2023
Licensee Name:	Central State Community Services, Inc.
Licensee Address:	Suite 201 2603 W Wackerly Rd Midland, MI 48640
Licensee Telephone #:	(989) 631-6691
Administrator:	Dale McAlpine
Licensee Designee:	Paula Barnes
Name of Facility:	Willow House
Facility Address:	400 North St Pinconning, MI 48650
Facility Telephone #:	(989) 879-2022
Original Issuance Date:	01/15/1991
License Status:	REGULAR
Effective Date:	11/06/2021
Expiration Date:	11/05/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 03/16/2023, Resident A was in her wheelchair to go to Cowboys at Heart concert. Staff Denise Briggs, forgot to put the lift up and Resident A went backwards on the lift to the ground. Three men from Cowboys at Heart helped get Resident A up, but the lift quit working. Staff Briggs took Resident A to the bathroom and checked her over. The nurse was not called until they returned back to the facility. The nurse instructed staff to do a head assessment, incident report, and watch Resident A throughout the night.	Yes

III. METHODOLOGY

04/27/2023	Special Investigation Intake 2023A0123038
04/28/2023	Special Investigation Initiated - Telephone I spoke with adult protective services worker Julie Anderson via phone.
04/28/2023	APS Referral I received information regarding the APS referral.
05/05/2023	Inspection Completed On-site I conducted an on-site at the facility with recipient rights to interview Resident A.
05/16/2023	Contact - Telephone call made I left a voicemail requesting a return call from staff Denise Briggs.
05/23/2023	Contact - Telephone call made I attempted to contact Staff Briggs via phone.
05/23/2023	Contact - Telephone call received I interviewed Staff Briggs via phone.
05/24/2023	Contact- Document Received I received a copy of Resident A's hospital discharge paperwork.
05/30/2023	Exit Conference I spoke with licensee designee Paula Barnes via phone.

ALLEGATION: On 03/16/2023, Resident A was in her wheelchair to go to Cowboys at Heart concert. Staff Denise Briggs, forgot to put the lift up and Resident A went backwards on the lift to the ground. Three men from Cowboys at Heart helped get Resident A up, but the lift quit working. Staff Briggs took Resident A to the bathroom to check her over. The nurse was not called until they returned back to the facility. The nurse instructed staff to do a head assessment, incident report, and watch Resident A throughout the night.

INVESTIGATION: On 03/17/2023, an *AFC Licensing Division-Incident/Accident* Report was completed regarding Resident A, for an incident that occurred on 03/16/2023 at 6:45 p.m.. The incident report states the following:

"[Resident A] was in her wheelchair to go to Cowboys at Heart Concert. I Denise Briggs forgot to put the lift up and she went backwards on the lift on the ground. 3 guys from Cowboys at Heart helped get her up but the lift quit working. I Denise Briggs took her to the bathroom to use bathroom and to check her over. No bruises or marks. I asked [Resident A] we should go back to Willow, and she said no she is okay and she said she is her own guardian. She wanted to stay, and she smiles, sang along to songs, joked around had coffee. When we got to Willow called RN Lynn. Lynn said to do head assessment and IR and watch over her through night. She didn't want Tylenol at first but then she asked & received."

In the corrective measures section of the report it states:

"Staff will be more cautious when using the van in the rain and at night. Staff will be aware of parking conditions and pavement conditions when using the van to maintain safety for all. Staff when available will seek a well-lighted area to park when using the van."

Further notes written by home supervisor Shawna Beaver states:

"While investigating what happened, I talked to [Resident A] and she stated that the van lift was not on the ground as stated by the staff but lowered in the correct position to enter on the ramp from inside of the van, then to be lower to the ground. She stated that she is not sure what happened with the staff if she fell, tripped, or had another possible medical condition that resulted with the staff falling onto her and then them both falling off the lift to the ground. [Resident A] stated that she did feel fine and that nothing at all was hurting her and that she wanted to enjoy the concert."

On 04/28/2023, I spoke with adult protective services investigator Julie Anderson via phone. Ms. Anderson stated that she has interviewed Resident A, and Resident A reported that staff Denise Briggs did not pull up the van lift, so she (Resident A) fell and hit her head. Both Ms. Briggs and Resident A stayed for the concert, then went back to the facility. Resident A went to the hospital later. Resident A denied having a

concussion. Ms. Anderson stated that Resident A is her own person, does not have a guardian, and that Resident A did not express any concerns.

On 05/05/2023, I conducted an on-site visit with Bay Arenac Behavioral Health recipient rights investigator Kevin Motyka. Mr. Motyka and I interviewed Resident A, and her husband Relative 1.

Resident A stated that the lift was down. Staff Briggs gave her a push, but she pushed too far. Resident A stated that she landed on her back on the van ramp. She stated that it did not hurt that bad, but it was a shock. She stated that she asked Ms. Briggs to go and get help, so Staff Briggs went inside the church to get two men. Resident A stated that it was pouring raining the night this occurred. She stated that Staff Briggs was the only staff person present with her, as well as two other residents that were in the van. She stated that the hospital did x-rays that night, and there were no issues.

Resident A stated that her back was a little sore from laying on the lift. She denied hitting her head. She stated that she just tried to brace the fall. She stated that a guy had a hard time helping her lift upright in her wheelchair. She stated that Staff Briggs took her into the church, they listened to the music for a while, then they went home. Resident A stated that Staff Briggs did check her over in the parking lot. She stated that she was soaking wet from the rain and cold, so she just wanted to get inside the church to dry off and warm up. She stated that they stayed at the church listening to music for about 20 minutes.

Relative 1 stated that he visits daily. He has no concerns about Resident A's care. He stated that he thinks the issue with Staff Briggs was an accident and not intentional.

On 05/05/2023, during this on-site, I observed the other residents in the home and obtained documentation. The other residents present in the home appeared to be clean and appropriately dressed. I obtained copies of documentation regarding Resident A. *Resident A's Assessment Plan For AFC Residents* dated 01/09/2023 was reviewed. For "*Moves Independently in Community*" it states that Resident A "*will be accompanied with staff when in the community unless with family*." For "Walking/Mobility" it states, "*needs assistance with long distance*." For "*Special Equipment Used*" it states, "*does have order for wheelchair use in public for long distance walking*." A copy of Resident A's physician order for her wheelchair was reviewed as well. She was prescribed a standard wheelchair on 09/23/2022.

Verification of a 06/23/2021 van safety demonstration/training sign-in sheet was obtained as well. Staff Denise Briggs' signature is noted.

On 05/23/2023, I interviewed staff Denise Briggs via phone. She stated that they went to the concert. She was unloading with the van lift. The other two residents were already out of the van. She failed to put the lift down. She took a step forward,

then she fell, then Resident A fell. She stated that heading back to the facility, she also got lost on the way back. She stated that it was a rainy day that day.

On 05/24/2023, I received a copy of Resident A's hospital discharge paperwork from Ascension Standish Hospital. The paperwork is dated for 03/17/2023. Resident A's admission time is 00:33 (i.e., 12:33 a.m.). The discharge diagnosis is listed as head injury and hypertension. She received a CT scan and x-rays. Under "*Additional Notes and Instructions*" on page four of nine, it states "*Patient may have suffered a mild concussion from the fall. Return to the ER for any decline in mental status, difficulty walking or any other concerning changes in behavior. Also return if blood pressure remains above 190 and does not respond to blood pressure medication*."

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:	An incident report dated for 03/16/2023, authored by staff Denise Briggs states that she forgot to put the van lift up, and this caused Resident A to fall backwards. Resident A was interviewed and confirmed she fell. Staff Denise Briggs was interviewed and stated that she failed to put the lift down, and that resulted in Resident A falling. There is a preponderance of evidence to substantiate a rule violation in regard to Staff Briggs not attending to Resident A's safety, which resulted in Resident A falling from a van lift.
CONCLUSION:	**VIOLATION ESTABLISHED**

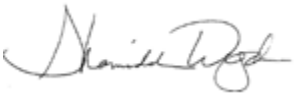
APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	An incident report dated for 03/16/2023, authored by staff Denise Briggs states that she forgot to put the van lift up, and this caused Resident A to fall backwards.

	Resident A was interviewed and confirmed she fell. Staff Denise Briggs was interviewed and stated that she failed to put the lift down, and that resulted in Resident A falling. Staff Briggs did not immediately contact the nurse to get instruction on care after the incident. Resident A did not go to the hospital until early morning on 03/17/2023. Per the incident report, the incident was noted to have occurred at 6:45 pm on 03/16/2023. There is a preponderance of evidence to substantiate a rule violation in regard to Staff Briggs not seeking immediate medical care after Resident A's fall. Resident A received a delay of medical attention.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 05/30/2023, I conducted an exit conference with licensee designee Paula Barnes. I informed her of the findings and conclusions.

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC small group home license (capacity 1-6).



05/30/2023

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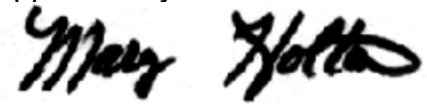
Shamidah Wyden Date
Licensing Consultant

Approved By:



05/30/2023

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Mary E. Holton Date
Area Manager