GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 29, 2024

Karon Lee
Michigan Community Services, Inc.
PO Box 317
Swartz Creek, MI 48473

RE: License #: AS090010213
Investigation #: 2024A0580014
Nebobish Road CLF

Dear Karon Lee:

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 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,

Sabrina McGowan, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 835-1019

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS090010213
Investigation #:	2024A0580014
Complaint Receipt Date:	12/26/2023
Investigation Initiation Date:	12/27/2023
Report Due Date:	02/24/2024
Licensee Name:	Michigan Community Services, Inc.
Licensee Address:	5239 Morrish Rd. Swartz Creek, MI 48473
Licensee Telephone #:	(810) 635-4407
Administrator:	Karon Lee
Licensee Designee:	Karon Lee
Name of Facility:	Nebobish Road CLF
Facility Address:	1405 W. Nebobish Road Essexville, MI 48732
Facility Telephone #:	(989) 892-0948
Original Issuance Date:	08/07/1986
License **Status:**	REGULAR
Effective Date:	02/28/2023
Expiration Date:	02/27/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was allowed to drink coffee. Resident A's plan of service dictates Resident A is only to received pureed foods and thickened liquids.	Yes

III. METHODOLOGY

12/26/2023	Special Investigation Intake 2024A0580014
12/26/2023	APS Referral This complaint was denied by APS for investigation.
12/27/2023	Special Investigation Initiated - Letter Email to Recipient Rights investigator, Kevin Motyka.
01/04/2024	Inspection Completed On-site Unannounced onsite inspection.
01/04/2024	Contact - Face to Face Observation of Resident A.
01/05/2024	Contact - Telephone call received Spoke with Karon Lee, license administrator
01/19/2024	Contact - Document Received Email from Karon Lee, License Administrator.
01/19/2024	Contact - Telephone call made Spoke with direct staff, Katrina Popp.
01/19/2024	Contact - Telephone call made Spoke with Julia Grusmick of Bay Arenac Behavioral Health, assigned case manager for Resident A.

01/19/2024	Contact - Telephone call made Spoke with RR Investigator, Kevin Motyka.
01/29/2024	Exit Conference Exit conference held with the licensee designee, Karon Lee.

ALLEGATION:

Resident A was allowed to drink coffee. Resident A's plan of service dictates Resident A is only to received pureed foods and thickened liquids.

INVESTIGATION:

On 12/27/2023, I received a complaint via BCAL Online Complaints. This complaint was denied by APS for investigation.

On 12/27/2023, an email was sent to Kevin Motyka, Recipient Rights (RR) investigator in Bay County. Kevin Motyka shared the complainant information.

On 01/04/2024, I conducted an unannounced onsite inspection at Nebobish Road CLF. Contact was made with direct staff Maeve Banaszek. Staff Banaszek recalled that on the day in question, 12/17/2023, she observed staff, Katrina Popp, lifting a cup to Resident A's mouth, telling him to take a drink. When Staff Banaszek inquired what was in the cup, Staff Popp informed that she was giving Resident A coffee and prune juice to assist with a bowel movement. Nothing happened as a result. No incident report was written to her knowledge.

While onsite I observed Resident A as he was sitting in a reclining chair in the living room. Resident A was browsing through a magazine, while reacting happily to the photos. Resident A was able to speak and said "hello". Per his assessment plan, due to Resident A's progressing dementia, Resident A is sometimes very confused and may just stare as if he has no conception of what they are saying. Other residents in the home were observed watching TV in the living room and in their rooms. The residents appeared to be receiving proper care.

On 01/05/2024, I spoke with Karon Lee, license designee (LD)/administrator for Nebobish Road home. LD Lee provided a copy of the Bay Arenac Individual Plan of Service (IPOS) and current diet plan for Resident A. The IPOS, effective 09/17/2023, states that to prevent choking and maintain safe eating, liquids are thickened to nectar-honey consistency if Resident A cannot tolerate regular liquids. All liquids are to be given to Resident A in a bowl and eaten with a spoon.

The Treatment Plan for Resident A, effective 09/22/2023, states that liquids are thickened to honey consistency. All liquids to be given in a bowl and eaten with a spoon.

On 01/19/2024, I spoke with Karon Lee, who provided a copy of the AFC assessment plan for Resident A. The plan, signed by Guardian A on 08/29/2023 and the licensee designee Karon Lee on 10/13/2023, indicates that staff will monitor for choking. Staff will also remind Resident A to take a bite, chew his food and drink his fluids. Karon Lee also provided a copy of the Short-Term Professional Orders written for Resident A, by RN Allison Blair, on 12/22/2023. The order indicates that Resident A is to have Thick-It with all fluids through 12/29/2023, or until doctor script comes in. She stated that this was written by the nurse, 5 days after this incident, to eliminate any confusion as to how the liquids should be given.

On 01/19/2024, I spoke with direct staff, Katrina Popp who indicated that Resident A had not had a bowel movement going on 5 days. Staff Popp admitted that she made the judgement call to give him the coffee with prune juice to assist. Staff Popp stated that she knew about the Thick-It, however, admittingly, she stated that did not use a thickening agent before administering Resident A the liquid. Staff Popp also stated that Resident A received the liquid concoction from a cup to his lips. No bowl or spoon was used.

On 01/19/2024, I spoke with Julia Grusmick of Bay Arenac Behavioral Health, assigned case manager for Resident A, who had not been made aware of this incident. Julia Grusmick shared that a thickening agent was recommended for Resident A's drinks to prevent choking and to continue to encourage his self-feeding as his dementia diagnosis worsens. Resident A has also had aspirational pneumonia in the past. To Julia Grusmick's knowledge, Resident A requires a thickening agent for all drinks. Julia Grusmick added that she has been the assigned case manager for Resident A since June 2022. Resident A is always well-groomed, smiling in a good mood, positive interactions with staff, and seems to be doing well in the home. Guardian A has expressed her gratitude regarding the care Resident A is provided in the home. Julia Grusmick has no current concerns.

On 01/19/2024, Kevin Motyka, RR Investigator, shared that he consulted with the physician, who stated that Resident A was put at risk of aspiration without the thick-it being in his liquid. He will be substantiating the case for neglect.

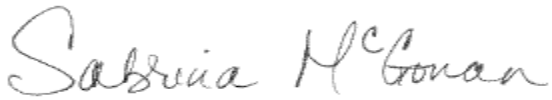
APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	It was alleged that Resident A was allowed to drink coffee. Resident A's plan of service dictates Resident A is only to received pureed foods and thickened liquids. Based on a review of the AFC Assessment Plan, the IPOS, and the Treatment Plan for Resident A, and interviews conducted with direct staff Maeve Banaszek, Katrina Popp, Licensee Designee Karon Lee, Recipient Rights Investigator Kevin Motyka, and Julia Grusmick of Bay Arenac Behavioral Health, assigned case manager for Resident A there is enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 01/29/2024, I conducted an exit conference with the licensee designee, Karon Lee, informing her of the findings of this investigation.

IV. RECOMMENDATION

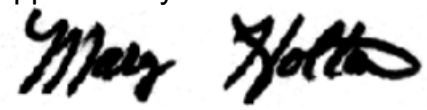
Upon the receipt of an approved corrective action plan, no change to the status of the license is recommended.



January 29, 2024

Sabrina McGowan Date
Licensing Consultant

Approved By:



January 29, 2024

Mary E. Holton Date
Area Manager