GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

March 1, 2024

Kimberly Morris
Sheffield Bay
4471 Sheffield Place
Bay City, MI 48706

RE: License #: AH090236892
Investigation #: 2024A0585021
Sheffield Bay

Dear Ms. Morris:

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) 284-9730.

Sincerely,

Brender L. Howard

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street, P.O. Box 30664
Lansing, MI 48909
(313) 268-1788
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH090236892
Investigation #:	2024A0585021
Complaint Receipt Date:	02/01/2024
Investigation Initiation Date:	02/01/2024
Report Due Date:	04/02/2024
Licensee Name:	Sheffield Bay LLC
Licensee Address:	4471 Sheffield Place Bay City, MI 48706
Licensee Telephone #:	(989) 684-6800
Administrator:	Kimberly Morris
Authorized Representative:	Jamie Rytlewski
Name of Facility:	Sheffield Bay
Facility Address:	4471 Sheffield Place Bay City, MI 48706
Facility Telephone #:	(989) 684-6800
Original Issuance Date:	08/12/1999
License Status:	REGULAR
Effective Date:	10/17/2023
Expiration Date:	10/16/2024
Capacity:	86
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was choking, and staff did not help him.	No
Resident B had a fall due to staff not following protocol.	Yes
Additional Findings	No

III. METHODOLOGY

02/01/2024	Special Investigation Intake 2024A0585021
02/01/2024	Special Investigation Initiated - Telephone Contacted APS worker John Jones for additional information.
02/01/2024	APS Referral These allegations were referred from Adult Protective Services (APS).
02/02/2024	Inspection Completed On-site Completed with observation and record review.
02/08/2024	Contact - Document Received Additional allegations received. Intake 199598 will be combined with this.
02/09/2024	Contact - Telephone call made. Contacted complainant on the additional allegations.
02/09/2024	Contact - Document Received Complainant emailed video footage of incident.
02/21/2024	Contact – Document Sent Emailed administrator Kim Morris for additional information.
02/21/2024	Exit Conference Completed via email.

ALLEGATION:

Resident A was choking, and the staff did not help him.

INVESTIGATION:

On 2/1/2024, the department received the allegations from Adult Protective Services (APS) via the BCHS Online Complaint website. The complaint read, "On 01/29/2024, incident occurred with an unknown male resident [A] who was choking in the dining room. A different unknown female staff member was going to help him, but then she realized he was a DNR, so she let him die."

On 2/8/2024, a second complaint was received via BCHs Online Complaint website. The complaint read, that a resident was choking, and a staff went to assist him, but said that he had a DNR, and he died."

On 2/2/2024, an onsite was completed at the facility. I interviewed authorized representative Jamie Rytlewski and administrator Kim Morris at the facility. Ms. Rytlewski stated that Resident A was choking because of food lodged in his throat. She stated that the aides attempted to dislodge the food. She said the hospice nurse came in to assist and she was successful in dislodging the food, but the family told them to stop with life saving measures because Resident A had a do not resuscitate order (DNR). Ms. Morris' statements were consistent with Ms. Rytlewski.

During the onsite, I interviewed hospice nurse Lisa Brent who stated that she was present during Resident A choking. She said the staff did good and taking care of Resident A when he was choking. She said they went into action immediately until she took over. She said after the food came up, Resident A was turning blue and because a DNR was in place, they could no longer administer CPR.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	Resident A was choking, and staff came to his aide to remove food from his mouth. However, Resident A began to turn black and blue. Resident A has a DNR order. EMS was called. The facility reasonably complied with this rule.

CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident B had a fall due to staff not following protocol.

INVESTIGATION:

The complaint read, “Resident [B] passed away today on 01/31/2024 due to an incident on 01/29/2024 when one unknown female staff was not following the two-person assist orders. Resident B ended up falling and breaking her shoulder, humerus, nose, and internal bleeding in her brain was suspected.”

On 2/8/2024, a second complaint read, “The facility had documentation stating that two people were supposed to assist my mother to and from the bathroom every 3 hours and then back to her recliner chair- which she slept in. She was not assisted properly, with 2 people as directed. She fell -hitting her face on her wheeled walker and floor as a result. I have Ring camera video of the entire incident. She suffered a dislocated shoulder, fractured upper arm and two severely black eyes and cuts on the bridge of her nose. She died the next day. There were several times when she was not taken to the bathroom for long periods of time. The longest time she went without being taken to the bathroom was 14 hours. She sat in her recliner the entire time. She developed a UTI as a result. There were also times when they forgot to bring her meals. Various employees at the facility have told me that they are often understaffed.

Ms. Rytlewski stated that two people were in Resident B’s room, with one being next to the other one. Ms. Rytlewski stated that one of the staff turn around to grab something and resident fell forward. She said Resident B has a walker and her legs gave out. She stated they asked the family for a bedside commode, but family wanted to keep her up. She stated that Resident B passed away the next day. Ms. Rytlewski said that Resident B was on hospice, and they suggested that she goes out to the hospital. She stated that if a resident hit their head, they automatically send them out, but the family did not want her to go out. She explained that after an x-ray was completed, Resident B had a fracture shoulder, they decided not to treat her but give her morphine to make her comfortable.

On 2/9/2024, I interviewed complainant on the second complaint. Complainant’s statements were consistent with what was in the written complaint. She stated that should be two staff to help resident to the bathroom. She stated that resident has a walker and she fell, hitting her face.

On 2/16/2024, I interviewed Employee #1 by telephone. Employee #1 stated that on the day of the incident, she was in Resident A’s room with Employee #2. She said that there was an order for two staff to assist the resident. She said that Employee

#2 was holding Resident A's oxygen tank when resident began falling. She said at that time, she was getting Resident A some pants from the closet in the room. She said that when Resident A fell, she left the room to get help to get Resident A off the floor.

On 2/21/2024, I interviewed Employee #2 by telephone. Employee #2 stated that she and Employee #1 went to take Resident A to the bathroom. She stated that Resident A was having a hard time and complained about her legs. Employee #2 stated that Resident A's legs were swollen and leaking. She said that her and Employee #1 were able to get Resident A up together when she was in the bathroom. Employee #2 explained that she was holding Resident A to the side by her pants with the walker in front of the resident. She said that Resident A wanted to stop, but she told her to we had to keep going to the chair. Employee #2 said that the walker was moving in front of her, when she began to lose her balance and fell. She stated that no one could have prevented her from falling because she was going down either way.

On 1/29/2024, the camera footage was forwarded to me. In the video, I can see Employee #1 and Employee #2. I saw Employee #2 standing outside of the bathroom and as the video continues, Resident A walks out the bathroom using her walker as Employee #2 walks behind her holding the back of the resident's pants. You can see Employee #1 going through what appears to be a closet. In the video, Employee #2 starts pulling up Resident A's pants and holding on to the back of her pants while she stops walking. The walker appears to be getting away, moving forward from the resident and she stops, but the walker appears to continue moving forward. Resident A appears to be losing her balance. Resident A was mumbling something, and Employee #2 tells her that "it's okay". The walker continued to move faster in front of Resident A and she fell hard to the floor, hitting her head on the walker and began yelling out as Employee #2 told her to hold on. Resident A continued to moan, "help, help". Employee #1 can be seen exiting the room. Resident A was still moaning and saying help. Employee #2 told Resident A that help was coming. Employee #2 the yelled, "is someone coming". Employee #1 came back into the room with another employee. Employee #2 moved the walker and the video stopped.

The entire video recording indicates to be approximately 2 minutes and five seconds in length.

Incident reports was consistent to what was reported.

Resident B's service plan with the assessment date of 11/16/2023 read, "Has fluid retention in both legs, one assist with the use of her walker and gait belt for mobility/ambulation." In the section marked transferring, it notes that resident is one assist with the use of her walker. It also has one assist, walker and gait belt checked in that section. In the section marked toileting, it read, "one assist to the bathroom.

She is incontinent and wears briefs and pads. She is also on a two-hour toileting schedule.

Resident B's service plan with the assessment date of 8/22/2023 read, "Resident is a regular healthy diet, can eat his meals independently and does not require the use of adaptive equipment. [Resident B] will need assistance getting to and from the dining room." The plan notes that Resident B is a do not resuscitate. The plan notes, on 1/29/2024, "resident had a fall which resulted in an injury to right arm and bruising on face. Family declined her going to hospital for treatment. Hospice nurse brought in a sling for her to wear to immobilize the arm. Hospital bed ordered. Resident is now bed bound. Hospice made medication changes to pain meds."

A review of police report, incident #24-000363, from Bay County Sheriff Department as reported by Officer Maddison Kalinowski stated, investigation is pending medical record review.

On 2/22/2024, APS worker John Jones said that he will be substantiating this case, and he has closed his investigation.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
R 325.1901	**Definitions.**
	(p) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the hone, or when the resident's service plan states that the resident needs continuous supervision.
	(t) "Service plan" means a written statement prepared by the home in cooperation with a resident, the resident's authorized representative, or the agency responsible for a resident's placement, if any, that identifies the specific care and maintenance, services, and resident activities appropriate for the individual resident's physical, social and behavioral needs and well-being, and the methods of

	providing the care and services while taking into account the preferences and competency of the resident.
ANALYSIS:	Resident A was not treated consistent with her service plan. A video recording revealed Resident A was walking with one staff, while the other staff was at the closet, fell hitting her head and face. One staff was observed holding the back of Resident A's pants with the walker in front of her and you could clearly see the walker sliding from the resident as she fell. Employee 2 did not use a gait belt. Employees did not follow Resident A's service plan that includes ambulating with the assistance of one with the use of her walker and gait belt.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, it is recommended that the status of the license remains unchanged.

Brender L. Howard 03/01/2024

Brender Howard Date
Licensing Staff

Approved By:

Andrea L. Moore 03/01/2024

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section