GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 22, 2024

James Pilot
Bay Human Services, Inc.
P O Box 741
Standish, MI 48658

RE: License #:	AS060068988
Investigation #:	2024A0123031
	Almont AFC

Dear James Pilot:

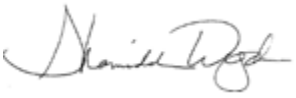
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AS060068988
Investigation #:	2024A0123031
Complaint Receipt Date:	04/03/2024
Investigation Initiation Date:	04/04/2024
Report Due Date:	06/02/2024
Licensee Name:	Bay Human Services, Inc.
Licensee Address:	PO Box 741 3463 Deep River Rd Standish, MI 48658
Licensee Telephone #:	(989) 846-9631
Administrator:	Tammy Unger
Licensee Designee:	James Pilot
Name of Facility:	Almont AFC
Facility Address:	140 Almont Street Standish, MI 48658
Facility Telephone #:	(989) 846-9648
Original Issuance Date:	08/01/1996
License Status:	REGULAR
Effective Date:	02/01/2023
Expiration Date:	01/31/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A has a fracture in their foot caused by significant force. Resident A should not have any injuries as Resident A is non-weight bearing.	Yes

III. METHODOLOGY

04/03/2024	Special Investigation Intake 2024A0123031
04/04/2024	APS Referral Information received regarding APS referral.
04/04/2024	Special Investigation Initiated - Telephone I spoke with APS investigator Tina Thompson via phone.
04/05/2024	Inspection Completed On-site I conducted an unannounced on-site at the facility.
04/12/2024	Contact - Document Sent I sent an email to the facility requesting documentation.
04/18/2024	Contact - Telephone call received I received a voicemail from APS investigator Tina Thompson.
04/26/2024	Contact - Telephone call made I left a voicemail requesting a return call from staff Ashley Daughtery.
04/26/2024	Contact - Telephone call made I interviewed staff Amanda Rice.
04/26/2024	Contact - Telephone call received I interviewed Staff Daughtery via phone.
04/26/2024	Contact - Telephone call made I left a voicemail requesting a return call from Resident A's case manager Ben Tenny.
05/07/2024	Contact - Telephone call received I spoke with Resident A's case manager Ben Tenny via phone.
05/08/2024	Contact- Document Received

	Requested documentation received via email.
05/13/2024	Inspection Completed On-site I conducted a follow-up on-site visit at the facility.
05/16/2024	Contact- Telephone call made I interviewed staff Roxy Stewart via phone.
05/16/2024	Contact- Telephone call made I interviewed staff Chloe Hewitt via phone.
05/16/2024	Contact- Telephone call made I left a voicemail requesting a return call from staff Cai Austin.
05/21/2024	Contact- Telephone call received I interviewed staff Cai Austin.
05/21/2024	Exit Conference I spoke with administrator Tammy Unger via phone.

ALLEGATION: Resident A has a fracture in their foot caused by significant force. Resident A should not have any injuries as Resident A is non-weight bearing.

INVESTIGATION: On 04/04/2024, I spoke with adult protective services investigator Tina Thompson via phone. She stated that so far no one knows how Resident A's injury occurred. Resident A is non-ambulatory. Staff have to use an ARJO lift for Resident A. Resident A is non-verbal, and staff denied knowing what happened.

On 04/05/2024, I conducted an unannounced on-site at the facility. I spoke with home manager Tabitha Johnson. Staff Johnson stated that she has her suspicions on what could have happened. She stated that Resident A received a bath one evening, and a bruise was found the next morning. She stated that she thinks Resident A's foot may have been bumped on the bathtub or something. Resident A's legs are contracted, and Resident A's legs are bent back when in the ARJO lift. Staff Johnson stated that Resident A could have hit the side of the doorway while in the ARJO lift, or bathtub while in the ARJO lift. Resident A is now a two-person assist so a second staff can watch Resident A's feet. Resident A showed no signs of pain.

During this on-site I observed Resident A in bed. Resident A was not interviewed due to being non-verbal. Resident A's foot was seen as well. Staff Johnson stated that Resident A's foot is healing. Other residents observed during this on-site appeared clean and appropriately dressed. No issues were noted.

On 04/15/2024, I received requested documentation from the facility. An *AFC Licensing Division-Incident/Accident Report* dated 03/25/2024 at 7:30 am states that staff Amanda Rice and staff Chloe Hewitt noticed that Resident A's foot was bruised and swollen. They notified the home manager. Resident A was seen by a primary care physician that day. It notes that an x-ray was done but nothing was broken, and that an ultrasound was done to look for blood clots.

A *Medical Appointment's Progress Note* dated 03/25/2024, notes that Resident A was examined by Dr. Matt Lampha for a swollen bruised right foot, excessive wheezing, and needing an aloe vesta liquid foam peri cleaner. It is signed by Dr. Lampha. An x-ray was ordered. Under *Staff Notes* it says, "*possible blood clot, or fracture*." A *Diagnostic Radiology* report from McLaren Health Care dated 03/25/2024 notes there was an x-ray of Resident A's right ankle. It says "*Limited views of the right ankle were obtained. There is some indistinctness of the cortex of the talar dome which may be due to degenerative change, however an underlying fracture or osteochondral lesion cannot be excluded. AP radiograph of the right ankle recommended*." On the next page it states under "*Impression*":

1. *"Tiny ossific density along the lateral base of the proximal first metatarsal is suspicious for a small avulsion fracture."*
2. *"Lucency projecting over the distal third metatarsal may be protectional or secondary to a nondisplaced fracture. Correlation with site of pain recommended."*

A *Medical Appointment's Progress Note* dated 04/08/2024 was received. It notes that Resident A was seen at the Foot & Ankle Clinic in Bay City for an examination of the right foot. It notes under *Findings/Treatment Plan* "*possible nondisplaced osteochondral lesion of talus. Non weight bearing wheelchair bound 4 weeks will resolve issue*." The document is signed by a medical profession.

A copy of Resident A's *Assessment Plan for AFC Residents* dated 03/13/2024 notes that Resident A uses an ARJO lift and wheelchair, and for walking/mobility Resident A "*requires complete support to move*." A copy of Resident A's *Bay Arenac Behavioral Health Plan of Service* dated 02/27/2024 notes that Resident A has edema in the lower extremities.

On 04/18/2024, I received a voicemail from Tina Thompson. She stated that she spoke with Resident A's doctor's office who reported that the foot fracture is the result of the foot getting entangled in the ARJO lift or if Resident A's foot caught got the edge of a door and Resident A was shoved through the doorway. The injuries are not consistent with the foot hitting the side of the tub. The staff are now doing two-person assists instead of one-person assists.

On 04/26/2024, I interviewed staff Amanda Rice via phone. Staff Rice works third shift. She stated that when she left shift on a Friday morning (on 03/22/2024 per the staff schedule), Resident A's foot was fine. The next shift staff Rice worked, Staff

Rice stated that she came in and checked on the residents. On Saturday morning (03/23/2024), she went to get Resident A dressed, noticed Resident A's foot, and yelled for staff Chloe Hewitt to come in and look at Resident A's foot. Staff Rice stated that there were two little bruises at that time, one at the near the middle/arch of the foot, and the other closer to the back of the ankle bone/heel area. Staff Rice stated that she notified home manager Tabatha Johnson as well as first shift staff. She stated that when she came back in to work later that night, Resident A's foot did not look different, but by Sunday morning the bruising grew on the side and bottom of Resident A's foot, and it was swollen. She stated that she informed Staff Johnson. She stated that she returned to work that Sunday (03/24/2024) and worked that night, and Monday morning she got Resident A dressed again, and showed Staff Johnson the bruising. She stated that Staff Johnson did whatever she did from that point forward. Staff Rice stated that Resident A is now a two-person assist. No staff ever said anything about what happened, and Resident A received medical treatment that Monday morning (03/25/2024). She stated that Resident A showed no signs of pain. Staff Rice stated that staff were asking one another about it at shift change. A couple of days later, Staff Rice stated she noticed a water blister on Resident A's other foot. Staff Rice mentioned reporting it to the nurse. Staff Rice stated that staff Brittany Swartz said, "*Over a blister*?" in response, and then stated "*Welp, [Resident A], looks like I'm going to jail. I was the one that worked the night she got bruises.*" Staff Rice stated that Staff Swartz was making off the wall comments and was acting scared of getting in trouble/losing her job. Staff Rice stated that Staff Swartz and Staff Roxy Stewart worked the night staff believes Resident A got bruised. She stated that Staff Swartz appeared upset about having to call the nurse for the blister, and Staff Rice stated that this comment was concerning. Staff Rice stated that Resident A receives showers on second shift after nighttime medication passes.

On 04/26/2024, I interviewed staff Ashley Daughtery via phone. She stated that she worked Friday (03/22/2024 8:00 am to 8:00 pm per the staff schedule), came back on 03/23/2024, and was told Resident A had a bruise. She stated that she is 100% confident that Resident A did not have a bruise when she left her shift at 8:00 pm Friday (03/22/2024). Staff Daughtery stated that everyone thinks that something happened with Resident A during bath time, and that Resident A gets baths after 8:00 pm medications are passed. She stated that staff Cai Austin told her that Resident A had a small bruise on the foot. Staff Daughtery stated that she never personally saw the bruise while she worked over that weekend. She stated that on 03/22/2024, Staff Brittany Swartz did a brief change around 5:00 pm and noted no bruising. She stated that staff Roxy Stewart came in to work at 8:00 pm to relieve Staff Daughtery. Staff Daughtery stated that Resident A's knee would get bumped when in the ARJO and going over bumps, and staff have to angle Resident A and be more careful. She stated that Resident A is a two person assist now.

On 05/07/2024, I spoke with Ben Tenny from Bay Arenac Behavioral Health. Ben Tenny stated that he was Resident A's case manager from late February 2024 until yesterday (05/06/2024). He stated that it seemed like the injury was an accident.

The staff did not fess up about how it happened. He stated that he was told it was a bruise, not an actual fracture. He stated that the home manager Tabitha Johnson did keep him in the loop. He denied having any care concerns prior to this incident.

On 05/08/2024, I received a copy of Resident A's *Monthly Physician Orders/Medication Orders* dated 04/01/2022 through 12/31/2022 that has Arjo Lift listed. It is signed by a family practitioner.

On 05/13/2024, I conducted a follow-up on-site at the facility. I interviewed staff Brittany Swartz. She stated that she worked Friday (03/22/2024) and started her shift at 4:00 pm. She stated that she provided personal care to Resident A that day and did not notice bumping Resident A's foot. Staff Swartz stated that she never saw a bruise and was told that staff observed a bruise the following morning, and it got bigger on Sunday, two days later. She stated that it was a few weeks before it was announced that Resident A had a fracture, because it took the physician a long time to tell the facility there was a fracture. Staff Swartz stated that Resident A is a two-person assist. When asked about the comments she made, she stated that she was nervous because everyone was looking at that Friday (03/22/2024) thinking that was when the injury happened. Staff Swartz denied doing anything to Resident A. She stated that Resident A's foot could have bumped the tub or maybe the doorway, but she did not notice that.

On 05/15/2024, I spoke with Bay Arenac Behavioral Health nurse Linda Thomas via phone. She stated that Resident A had a fractured toe (metatarsal), and they could not get a view to confirm other possible fractures. Resident A saw an Osteopath who said if there was a fracture, it would heal on it's own. Resident A could not wear a boot on the foot due to Resident A's contractures. Resident A is non-weight bearing anyway. Nurse Thomas stated that staff did contact her when they noticed Resident A bruised and swollen. She stated that Resident A always appears puffy/swollen anyway and wears a ted hose during the day. She stated that Resident A's foot probably swelled bigger after the ted hose was taken off, as Resident A does not sleep during the night with a ted hose on. Nurse Thomas stated that no staff stepped up to say that they remember how it happened. She stated that they discussed how it may have happened. She stated that Resident A's physician said that staff would know if they ran into something because it would have been hard, since it caused a fracture. Nurse Thomas stated that she wrote an order for Resident A to be a two-person assist. Nurse Thomas stated that staff were very concerned, but no one stepped forward to say "*it may have been me*." She stated that Resident A had an avulsion fracture, caused by a push, or pull, and the doctor was concerned about this and said it could have happened going through a doorway or hitting the tub. She stated that as a result, she ordered the two-person assist. She stated that the doctor did not think that anyone did anything to Resident A (intentionally), and that it was an accident. Nurse Thomas stated that Resident A is total care and is contracted. Resident A does not fit in the sling like other people do. She stated that she does not think anything was done intentionally, and they do not know exactly how it happened.

On 05/16/2024, I interviewed staff Roxy Stewart via phone. Staff Stewart stated that she did not provide personal care to Resident A on 03/22/2024 and did not see anything happen to Resident A. She stated that she did not hear about anything until a few days later. She stated that Staff Swartz did most of the personal care, and staff Swartz was assigned to Resident A. She stated that Staff Swartz never mentioned anything about the foot. Staff Stewart stated that she saw the bruising after the fact. She stated that Resident A had an x-ray done. She stated that she knows that something was broken, and since the incident, Resident A is now a two-person assist.

On 05/16/2024, I interviewed staff Chloe Hewitt via phone. Staff Hewitt stated that she worked with staff Amanda Rice when Staff Rice noticed a little bruise on the side of Resident A's heel that was purple. She stated that by that Sunday (03/24/2024), Resident A's foot was really swollen. She stated that she informed management. She denied knowing how it happened and stated that she wasn't assigned to and did not provide Resident A with personal care during that time.

On 05/21/2024, I received a return call from staff Cai Austin. She stated that she worked the weekend Resident A's foot was found to have bruising. She stated that third shift staff Amanda Rice brought her into Resident A's room Saturday morning (03/23/2024). She stated that the bruising was dark colored on the side of Resident A's foot. She stated that at bath time on 03/23/2024, there was a small bruise that showed up on the bottom middle part of Resident A's foot. She stated that at that time nothing was concerning as staff had already done a skin audit, incident report, and contacted management. She stated that Resident A had no signs of pain. She stated that she did not see the bruising the following day on Sunday (03/24/2024) as she did not provide personal care to Resident A that day. She stated that Resident A received medical attention on 03/25/2024 after management saw the bruising that day. She stated that no one knows what happened. It is not really common for Resident A to have bruising on the foot, but Resident A's feet are always swollen. She stated that she has never seen Resident A voluntarily move their legs as Resident A has contractures. She stated that as of now the bruising is gone, as well as the swelling, aside from Resident A's regular swelling.

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:	On 04/05/2024, I conducted an unannounced on-site visit. I spoke with home manager Tabitha Johnson. She stated that it is unknown how Resident A's injury occurred, but it is believed that Resident A's foot was bumped while being transferred in the ARJO lift. She stated that Resident A is now a two-person

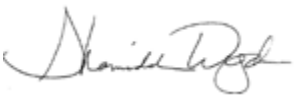
	assist. Resident A was observed during this on-site. Resident A could not be interviewed due to being non-verbal. Resident A is immobile and requires full assistance from staff for any movement. Resident A's *Assessment Plan for AFC Residents* notes the use of an ARJO lift. A physician's order was reviewed that had ARJO lift listed as well. An *AFC Licensing Incident/Accident Report* notes that Resident A was seen by a primary care physician on 03/25/2024 for the swollen and bruised foot. An x-ray was completed, but no fractures were seen. Medical documentation from 03/25/2024 notes that a fracture could not be excluded. It is documented that Resident A an x-ray completed on 03/25/2024, that found suspicion of a small avulsion fracture of the first metatarsal. Resident A had a follow-up appointment with the Foot & Ankle Clinic in Bay City on 04/08/2024, and the notes from that visit stated that Resident A had a possible nondisplaced osteochondral lesion of the talus. On 05/07/2024, I spoke with Resident A's case manager Ben Tenny who reported that he was kept in the loop regarding what was going on, and that Resident A's bruising was reported to him. He denied having any concerns about Resident A's care prior to this incident. On 04/26/2024, I interviewed staff Amanda Rice who noticed small bruising the morning of 03/23/2024, and then on Sunday morning, Resident A's bruising was larger and the foot was swollen. Staff Rice stated that she notified management both times. Staff Ashley Daughtery was interviewed and denied seeing any bruising on the end of her shift on 03/22/2024 or throughout the weekend. On 05/08/2024, I interviewed staff Brittany Swartz at the facility. She stated that she provided personal care to Resident A on 03/22/2024 but never saw a bruise and denied do anything to Resident A. She did state that Resident A could have bumped their foot on the tub or doorway, but she did not notice anything. On 05/15/2024, I spoke with Linda Thomas, RN of Bay Arenac

	Behavioral Health. She stated that Resident A had a fractured toe (metatarsal)/avulsion fracture, but they could not get a view to confirm other possible fractures. She stated that Resident A's foot always appears puffy/swollen and that Resident A consistently wears a ted hose during the day. She stated that it is unknown how the injury occurred. On 05/21/2024, I interviewed staff Cai Austin who reported seeing the bruising but denied knowing what happened. There is a preponderance of evidence to substantiate a rule violation due to Resident A obtaining an injury due to an unknown cause.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 05/21/2024, I conducted an exit conference with administrator/designated person Tammy Unger via phone. I informed her of the findings and conclusion.

IV. RECOMMENDATION

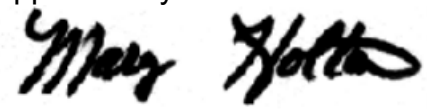
Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC small group home license (capacity 1-6).



05/21/2024

Shamidah Wyden Date
Licensing Consultant

Approved By:



05/22/2024

Mary E. Holton Date
Area Manager