GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 4, 2024

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

RE: License #:	AS090395688
Investigation #:	2024A0872034
	Rose Home

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.
- 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,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS090395688
Investigation #:	2024A0872034
Complaint Receipt Date:	04/12/2024
Investigation Initiation Date:	04/15/2024
Report Due Date:	06/11/2024
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:	Rose Home
Facility Address:	308 Ireland Auburn, MI 48611
Facility Telephone #:	(989) 662-4595
Original Issuance Date:	10/01/2018
License Status:	REGULAR
Effective Date:	04/01/2023
Expiration Date:	03/31/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 04/07/24, Resident A was not eating/drinking. On 04/08/24, Resident A had an unwitnessed fall. Staff failed to notify Resident A's nurse when she refused to eat/drink and when she had an unwitnessed fall.	Yes

III. METHODOLOGY

04/12/2024	Special Investigation Intake 2024A0872034
04/15/2024	Special Investigation Initiated - Letter I made an APS complaint via email
04/15/2024	APS Referral I made an APS referral via email
04/18/2024	Inspection Completed On-site Unannounced
05/29/2024	Contact - Telephone call made I interviewed staff Christina Salo
06/03/2024	Contact - Telephone call made I interviewed Nurse Barbara Guerin
06/03/2024	Exit Conference I conducted an exit conference with the licensee designee, James Pilot
06/03/2024	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: On 04/07/24, Resident A was not eating/drinking. On 04/08/24, Resident A had an unwitnessed fall. Staff failed to notify Resident A's nurse when she refused to eat/drink and when she had an unwitnessed fall.

INVESTIGATION: On 04/18/24, I conducted an unannounced onsite inspection of Rose Home Adult Foster Care (AFC) facility. I interviewed the home manager (HM), Robin Lintern and Resident A and obtained AFC paperwork regarding this investigation.

According to HM Lintern, Resident A has a history of refusing to eat and/or drink when she is upset. Staff uses a behavior data sheet to track when she refuses to eat but they do not track how much she eats, and they are not required to track her fluid intake. HM Lintern said that if Resident A refuses to eat, staff are required to contact her nurse. HM Lintern spoke to staff Christina Salo who was working on 04/07/24. Staff Salo told HM Lintern that since Resident A refused to eat on three occasions, she tried to contact Resident A's nurse on 04/07/24 to notify her but the nurses' voicemail was full, and Staff Salo was unable to leave a message.

HM Lintern said that the next day, 04/08/24, Resident A did have an unwitnessed fall. Resident A did not have any marks, bruises, or injuries and she did not complain of any pain. Therefore, staff completed a head assessment and determined that no medical attention was needed. Staff completed an Incident/Accident (IR) report, but HM Lintern said the IR was not sent.

Resident A agreed to talk to me, but she was tearful and upset during this interview. Resident A had a difficult time staying on track, but she did answer my questions. I asked her if there are times that she refuses to eat or drink and she said yes. She said that sometimes she feels like staff shows favoritism to the other residents and this upsets her, so she does not want to eat. I asked her if she had a fall recently and she said yes. She said that she felt dizzy, while she was in the small bathroom. She fell and hit her head getting up off the toilet. According to Resident A, she called out for staff and staff came and helped her up. She said that she had a small bump on the back of her head from the incident. She told me that "Nurse Barb" came out later that day and examined her. Resident A said that she did not go to the hospital for treatment, and she has been "fine" since that incident.

On 05/29/24, I reviewed AFC paperwork related to this complaint. Resident A was admitted to Rose Home AFC on 01/30/2014. According to her Health Care Appraisal dated 05/16/23, she is diagnosed with an intellectual disability, PTSD, schizoaffective disorder, and an ambulatory disfunction. Resident A uses a walker to ambulate, and she is prescribed a 2000 calorie diet with no restrictions.

According to her Assessment Plan (AP) dated 12/11/23, Resident A does not require assistance with toileting, bathing, dressing, or personal hygiene. Resident A uses a gait belt, walker, and ankle braces for mobility. Resident A has a history of self-harm and verbal aggression. The AP does not state that Resident A has a history of falls.

According to Resident A's Bay Arenac Behavior Treatment Assessment (BTA) dated 12/06/22, she has cerebral palsy, mild intellectual disability, schizoaffective disorder; bipolar type, unspecified depressive disorder, other problems related to psychosocial circumstances, an unspecified personality disorder, a seizure disorder, a history of hypertension, a history of breast cancer (currently in remission), and a tendency to get frequent urinary tract infections. Resident A has had numerous psychiatric hospitalizations due to suicidal and homicidal ideations, and suicidal attempts/self-

injurious behaviors. Resident A has frequent complaints of pain or health concerns with no discernable diagnosis.

I reviewed her Plan Training Form (PTF) dated 01/03/24 and noted that staff Christina Salo signed it on 12/26/23. I reviewed Resident A's Behavior Data Sheet (BDS) for 04/05/24-04/07/24. According to this document, on 04/05/24 Resident A had one incident of not eating, and on 04/06/24 and 04/07/24, she had three incidents of not eating.

I reviewed her Bay Arenac Behavioral Health Nursing Care Plan (NCP) dated 03/07/24 completed by Barbara J. Guerin, BSN, RN. According to this document, Resident A is a high fall risk. Staff are required to complete an Incident/Accident (IR) report for all falls. Staff will complete a head injury assessment for any unwitnessed falls or if Resident A hits her head. Staff are to encourage her to use her gait belt and walker as prescribed. The NCP specifies that staff will weigh Resident A every week and will report a 2-pound weight change to her nurse. This document also states the following: "Staff will monitor and report asap: bluish color to lips or nailbeds; confusion; cough with green, yellow or bloody mucus; fever; heavy sweating; loss of appetite; shortness of breath; rapid breathing; loss of energy or extreme tiredness; sharp or stabbing chest pain." If staff are unable to reach a nurse within five minutes, they are to call 911 for assistance with any "respiratory decline."

I reviewed an IR dated 04/08/24 regarding Resident A. According to the IR, "(Resident A) yelled out 'Robin.' Staff stated she wasn't in and heard a loud sound. Staff went to bathroom. (Resident A) was on floor. Staff took vitals and head assessment/skin audit right away." The actions taken by staff were, "Did vitals, skin audit, fall report, called nurse, got her up, put in chair, gave carnation breakfast pudding, called house manager and RO." The corrective measures taken were, "Checked on (Resident A) when I returned to the home and made sure she was okay. Gently reminded her she needs to eat to fuel her body and prevent her from feeling faint." The IR does not specify the date and time it was sent to anyone. I reviewed Resident A's weight record from February 2024 through April 2024. I did not note any significant weight change for February and March 2024 but did note that Resident A's weight fluctuated from 153lbs on 04/06/24 to 150.5lbs on 04/13/24 which is a 2.5lb difference.

On 05/29/24, I interviewed staff Christina Salo via telephone. Staff Salo said that she has worked at this facility for almost two years, and she confirmed that she worked on 04/07/24. According to Staff Salo, she is aware that Resident A has a history of not eating or drinking at times and she is aware that staff must chart when this occurs. I asked her about the NCP, and she acknowledged that she has read and reviewed it but said that the instructions about when to contact the nurse are unclear. Staff Salo said that it is her understanding that staff do not need to contact Resident A's nurse every time Resident A refuses to eat or drink. Therefore, on 04/07/24 she charted Resident A's refusals and documented it in her progress notes, but she did not contact Resident A's nurse.

On 06/03/24, I interviewed Resident A's nurse, BSN, RN Barb Guerin via telephone. RN Guerin confirmed that Resident A is on her caseload and said that she has provided multiple in-service education trainings to staff about Resident A's needs. RN Guerin said that over the past two years, this facility has had numerous home managers and staff have not consistently implemented the care plans ordered. RN Guerin said that in addition to notifying her when Resident A refuses to eat and/or drink, staff is also required to notify her if Resident A experiences a 2-pound weekly weight difference and they are required to complete and submit an IR to her whenever Resident A experiences an unwitnessed fall.

RN Guerin confirmed that staff did not notify her of Resident A's refusals to eat and/or drink on 04/05/24 – 04/07/24 and they did not submit an IR to her regarding Resident A's fall on 04/08/24. In addition, RN Guerin said that when she reviewed Resident A's weights for April 2024, she found the following:

- 04/06/24 153lbs
- 04/13/24 150.5lbs
- 04/20/24 149.5lbs
- 04/27/24 146lbs

RN Guerin said that staff failed to notify her of Resident A's 2-pound weekly weight difference between 04/06/24 – 04/13/24 and 04/20/24 – 04/27/24. I spoke to RN Guerin about the medical needs of the residents in this facility and she said that most of the residents have significant medical needs. I discussed the fact that if a resident requires continuous nursing care and/or if the facility is no longer able to meet the needs of the resident, they are required to discharge the resident from the facility.

On 02/13/24, AFC Licensing received a complaint alleging that one of the residents had a significant weight loss that was not reported to her nurse or case manager. AFC Consultant, Shamidah Wyden investigated this complaint and substantiated R 400.310(1)(d). The designated representative/administrator, Tammy Unger submitted a corrective action plan on 04/01/24 stating that the home manager is responsible for ensuring that all doctor and nursing orders are followed. In addition, the Director of Residential Services, Tabatha Barnes will review all resident records twice a week for the next three months to ensure compliance.

On 06/03/24, I conducted an exit conference with the licensee designee (LD), James Pilot. I discussed the results of my investigation and explained which rule violation I am substantiating. I told LD Pilot that this is a repeat violation and explained that if substantial violations keep occurring, disciplinary action may result. I explained that if the facility is unable to meet the medical needs of these residents, the facility should be issuing a 30-day discharge notice. LD Pilot verbalized his understanding and said that he will complete and submit a corrective action plan upon the receipt of my investigation report.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	According to Resident A's Behavior Data Sheet (BDS), on 04/06/24 and 04/07/24, she refused to eat/drink on three separate occasions. According to staff Christina Salo, and Home Manager, Robin Lintern Resident A had an unwitnessed fall on 04/08/24. HM Lintern said that an Incident/Accident (IR) was completed but not sent to Resident A's nurse. According to Resident A's nurse, RN Barbara Guerin, staff did not notify her of Resident A's refusal to eat/drink on 04/06/27 and 04/07/24 and staff failed to send her an IR regarding Resident A's unwitnessed fall on 04/08/24. In addition, RN Guerin said that staff failed to notify her of Resident A's weight change from 04/06/24 – 04/13/24 and from 04/20/24 – 04/27/24. According to Resident A's Nursing Care Plan (NCP), staff are required to notify her nurse if she refuses to eat/drink, and if there is a 2-pound weekly weight difference. The NCP also states that staff is to complete and submit an IR to Resident A's nurse whenever she has an unwitnessed fall. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Ref. SIR #2024A0123023 and CAP dated 04/01/24.**

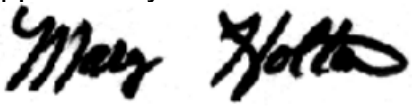
IV. RECOMMENDATION

Contingent upon the receipt of an appropriate corrective action plan, I recommend no change to the status of this license.

June 3, 2024

Susan Hutchinson Licensing Consultant	Date

Approved By:



June 4, 2024

Mary E. Holton Area Manager	Date