GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 2, 2024

Timothy Adams
Braintree Management, Inc.
7280 Belding Rd. NE
Rockford, MI 49341

RE: License #: AL340338193
Investigation #: 2024A0622042
Harrison House AFC

Dear Mr. Adams:

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) 284-9727.

Sincerely,

Amanda Blasius, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL340338193
Investigation #:	2024A0622042
Complaint Receipt Date:	07/08/2024
Investigation Initiation Date:	07/09/2024
Report Due Date:	09/06/2024
Licensee Name:	Braintree Management, Inc.
Licensee Address:	7280 Belding Rd. NE Rockford, MI 49341
Licensee Telephone #:	(616) 813-5471
Administrator:	Jessica Adams
Licensee Designee:	Timothy Adams
Name of Facility:	Harrison House AFC
Facility Address:	532 Harrison Avenue Belding, MI 48809
Facility Telephone #:	(616) 244-3443
Original Issuance Date:	04/02/2013
License Status:	REGULAR
Effective Date:	10/01/2023
Expiration Date:	09/30/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 7/6 evening, Resident A was found by a bystander. Resident A was observed face down on the ground. She had injured her face, nose, hands and arms. Direct care staff were not aware Resident A had left the facility.	Yes

III. METHODOLOGY

07/08/2024	Special Investigation Intake 2024A0622042
07/09/2024	Special Investigation Initiated - Telephone Phone call to Vicki Pohl, adult protective services worker.
07/24/2024	Phone call with guardian A1
07/24/2024	Inspection Completed-BCAL Sub. Compliance
07/30/2024	Email contact with Vicki Pohl, adult protective services worker.
07/31/2024	Phone call with direct care worker, Audrey Bishop.
08/02/2024	Exit conference with administrator Tim Adams

ALLEGATION: On 7/6 evening, Resident A was found by a bystander. Resident A was observed face down on the ground. She had injured her face, nose, hands and arms. Direct care staff were not aware Resident A had left the facility.

INVESTIGATION:
On 05/02/2024, I received this complaint through the Bureau of Community and Health Systems online complaint system. According to the complaint, Resident A was found by a bystander at 2:30am on the sidewalk in Belding face down. The bystander called the ambulance. The complaint reported that Resident A's feet were caked with dirt and her clothes were dirty and soiled. The clothes were heavily soiled with urine, briefs were also heavily soiled and there was no indication that she was changed recently. Resident A was able to leave out the front door. Staff was present but didn't see her leave according to Resident A. The AFC home had no knowledge that Resident A was missing until EMS knocked on the door.

On 07/09/2024, I interviewed adult protective services worker, Vicki Pohl via phone. Ms. Pohl reported that she was also investigating the allegations and stated that

Resident A received the following injuries from her fall: rib fracture, traumatic face injury and a potentially blocking kidney stone. Ms. Pohl reported that Resident A was still in the hospital.

On 07/24/2024, I interviewed Guardian A1 via phone. She reported that Resident A was now placed on hospice and was still in the hospital in Grand Rapids. She stated that Resident A's status was not improving and that she has a do not resuscitate order in place. Guardian A1 explained that over the last few months while living at the facility Resident A was becoming more confused and disoriented. Guardian A1 stated Resident A has had two falls within the last few months, one in the community and one down the facility stairs and after each fall her health and cognition seemed to decline. Guardian A1 explained that Harrison House AFC sent Resident A to the hospital for her falls or other health related concerns, but direct care staff did not attend the hospital visit with her. Guardian A1 stated that Resident A needed a staff member to advocate for additional medical procedures or ask additional questions during these visits to determine if there were underlying medical conditions. She reported that the hospital often just sent her back home with no findings. Guardian A1 stated she was concerned that Resident A was able to leave the facility in the middle of the night direct care staff were not aware that she was missing until the EMS knocked on the facility door. Guardian A1 reported that she was unaware that Resident A was wearing adult incontinence briefs.

On 07/24/2024, I completed an unannounced onsite investigation to Harrison House AFC. During the investigation, I interviewed direct care worker (DCW), Desire Wyatt in person. DCW Wyatt reported that Resident A has been placed on hospice and will not be returning to the facility. She explained that she was on a feeding tube, and they found a brain bleed. DCW Wyatt stated that Resident A was found at the end of their yard on the sidewalk by a bystander driving to work. The bystander called the ambulance. When the ambulance arrived, they knocked on the door at the facility and woke up the staff member who lives in the apartment connected to the facility. According to DCW Wyatt, DCW Audrey Bishop was not aware that Resident A had left the facility. When DCW Audrey Bishop last checked on Resident A at 11pm, she was sleeping in her bed stated DCW Wyatt. DCW Wyatt explained that Resident A was having a sleep study conducted that night (while in the facility) and had a cap and wires that were placed on her head. The sleep study company was monitoring her through a video camera that was placed in her room and another one in the living room. DCW Wyatt stated that a video camera was placed in the living room also, because Resident A had been getting up and wandering during her sleep and she tends to come sit in the living room. DCW Wyatt reported that Resident A wore adult incontinence briefs only because she was starting to have accidents, but she would change them herself and staff would just remind her to go to the bathroom. DCW Wyatt described Resident A over the last month as unstable and having a decline in her normal functioning. She reported that the sleep study was being done to determine why she was wandering in the middle of the night and to see if there were more underlying medical conditions. DCW Wyatt reported that Resident A used to be very active in the community and attending community groups and church, but

she had stopped going over the last month. DCW Wyatt reported that they had starting using a bed alarm in the middle of the night to wake up staff if she was getting up. On the night of her fall, the bed alarm was not placed on her bed according to DCW Wyatt. DCW Wyatt reported that she believes that Resident A hid the bed alarm in her closet, as she did not like the alarm going off.

On 07/24/2024, I viewed an incident report that was completed for Resident A falling in the community at 2am. I also viewed Resident A's *Assessment Plan for AFC Residents* which was updated on 5/30/24. It documented the following needs:

"Moves independently within the community: yes
Toileting: no
Bathing: Staff will assist with bathing
Dressing: staff will assist with any dressing assistance needed
Personal hygiene: staff will remind Resident A of female hygiene due to frequent UTI's
Walking/mobility: Walks independently in the home, but will use walker/cane when going into the community
Stair climbing: Resident is able to do stairs. Staff will assist when resident needs help carrying belongings down the stairs.
Use of assistive devices: uses a cane and walker at different times
Special Diets: diabetic diet"

On 07/30/2024, I had email contact with adult protective services worker, Vicki Pohl. She stated that she was able to talk with the live in staff member and the last time she observed Resident A in the facility was at 11pm in her bed sleeping.

On 07/31/2024, I interviewed DCW Audrey Bishop via phone. She reported that she is the live in staff member for Harrison House AFC. She stated that she sleeps during the 3rd shift, but usually checks on residents before she goes to bed at 11pm and then again at 4am. DCW Bishop reported that she also works 1st shift at the home. DCW Bishop stated that on 07/07/24, between 2am-3am she was woken up by knocks on her door. DCW Bishop stated EMT staff had woken her up and she went out with them and observed Resident A face down on the sidewalk at the end of the AFC property. DCW Bishop stated Resident A had a pop near her but her walker was not with her. DCW Bishop reported that Resident A was still wearing her sleep study cap on her head. She observed her face to be bleeding and it appeared that she tripped on the sidewalk. DCW Bishop reported that the ambulance took her to the hospital, and she called the home manager. DCW Bishop reported that Resident A was doing the sleep study in the home because it would have been too stressful for her to complete it outside of the facility. DCW Bishop stated that she believes the sleep study and having all the wires connected to her head was very stressful for her. She also explained that Resident A is diabetic, therefore she must have got into the refrigerator in the middle of the night and took the pop. DCW Bishop stated that her high sugar intake could have also contributed to her wandering and becoming confused. DCW Bishop reported that Resident A had been more confused for quite sometime and had started wandering more during the night

but had not left the facility. DCW Bishop reported that Resident A was needing more restrictions due to her increasing confusion. DCW Bishop stated DCWs reported they were attempting to monitor her more with the bed alarm. DCW Bishop reported that she did not work during the day on 07/06/2024, therefore she was unable to confirm that the bed alarm was in place before Resident A fell asleep. DCW Bishop reported that Resident A did not like the bed alarm and the alarm was not placed on her bed on the night of 07/06/24 before she fell asleep.

On 08/01/2024, it was confirmed through Guardian A1 that Resident A passed away on 07/30/2024.

On 06/24/2024, Special Investigation #2024A0622035 cited a rule violation of R 400.15206 (2). The special investigation documented that after review of the facility Evacuation Scores, the staff schedule and interviews, only one direct care staff was available for third shift, which is from 10pm-7am, despite four residents requiring two direct care staff member assistance with toileting and transfer assistance. The special investigation documented Harrison House AFC is not a sprinkled facility, therefore if a fire occurred, the four residents may not be able to evacuate the facility safely or at all during the hours of 10pm-7am (9 hour shift) due to only one staff being available. The *Corrective Action Plan* (CAP), dated 06/30/2024, and completed by Licensee designee Tim Adams and administrator, Jessica Adams noted: “Due to the e-scores it is evident at this time that we hire a second 3rd shift staff. Currently the sleep staff attends to individual clients when they use their call button for assistance to help whether it be for help in incontinence needs or any other needs. Incontinence assistance does not require two people when clients are in their beds. Only once staff is needed to assist when a client is in their bed. The need for a second staff seems to be with the concern of evacuating during a fire emergency. We will be developing a 3rd shift upstaff position and hope to have this in place within 90 days. The Administrative Home Manager, Desire Wyatt, will be responsible for developing this position with assistance from the Administrator and Licensee Designee.”

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.

ANALYSIS:	Based on interviews with Guardian A1 and direct care workers Audrey Bishop and Desire Wyatt, it was determined that an awake staff member was not available on the evening of 07/06/24 and early mornings of 07/07/2024 to provide supervision and protection for Resident A despite Resident A having previous episodes of wandering during the nighttime hours and experiencing previous falls with injuries. DCW Audrey Bishop did not assure Resident A's bed alarm was attached prior to her undergoing the sleep study and was also unaware that Resident A was awake and missing from the facility, therefore she was able to wander outside where she fell, sustained multiple injuries leading her to be hospitalized and placed on hospice.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE SIR#2024066035 AND CAP DATED 06/30/2024].**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend that the status of the license remains unchanged.

08/01/2024

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Amanda Blasius Date
Licensing Consultant

Approved By:

08/02/2024

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Dawn N. Timm Date
Area Manager