GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 25, 2021

Lisa Murrell
Community Living Centers Inc
33235 Grand River
Farmington, MI 48336

RE: License #: AM630009277
Investigation #: 2021A0605025
CLC Farmington Freedom

Dear Ms. Murrell:

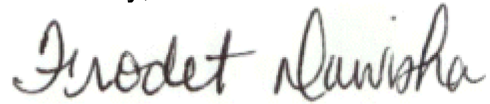
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM630009277
Investigation #:	2021A0605025
Complaint Receipt Date:	04/19/2021
Investigation Initiation Date:	04/19/2021
Report Due Date:	06/18/2021
Licensee Name:	Community Living Centers Inc
Licensee Address:	33235 Grand River Farmington, MI 48336
Licensee Telephone #:	(248) 478-0870
Administrator/Licensee Designee:	Lisa Murrell
Name of Facility:	CLC Farmington Freedom
Facility Address:	22550 Farmington Road Farmington, MI 48336
Facility Telephone #:	(248) 477-2336
Original Issuance Date:	04/14/1980
License Status:	REGULAR
Effective Date:	08/28/2019
Expiration Date:	08/27/2021
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Incident report (IR) received dated 04/18/2021 at 9AM stated Resident A fell out of his wheelchair while being transferred into bed. Resident A complained of leg and heel pain. Direct care staff (DCS) gave Resident A Tylenol. Resident A was taken via ambulance to the hospital on 04/19/2021. Resident A had a fractured right leg.	Yes

III. METHODOLOGY

04/19/2021	Special Investigation Intake 2021A0605025
04/19/2021	Special Investigation Initiated - Telephone Left message for Office of Recipient Rights (ORR) Alanna Honkanen regarding these allegations.
04/19/2021	Referral - Recipient Rights ORR referral made.
04/19/2021	APS Referral Adult Protective Services (APS) referral was made.
04/20/2021	Contact - Document Received ORR Alanna Honkanen emailed Resident A's individual plan of service and crisis plan completed by Macomb-Oakland Regional Center (MORC). She also emailed her interview with MORC support's coordinator Maureen McGurn.
04/21/2021	Inspection Completed On-site I conducted an unannounced on-site investigation. I interviewed the home manager Arleen Davis, the medication coordinator Donella Harris, Resident A and Resident B. I reviewed Resident A's health care chronological (HCC) and scripts for wheelchair and staff communication log.
04/22/2021	Contact - Telephone call received I received a voice mail message from APS worker Marcie Fincher stating she is investigating these allegations.
05/03/2021	Contact - Document Sent

	I emailed APS worker Marcie Fincher the staff log and Resident A's script dated 08/21/2019 regarding recommendation of only a wheeled walker and not the use of a regular wheelchair.
05/10/2021	Contact - Telephone call made I interviewed direct care staff (DCS) Felicia Todd and MORC support's coordinator Maureen McGurn regarding the allegations. I left a voice mail message for DCS Tameka Fricklin and ORR Alanna Honkanen.
05/12/2021	Contact - Document Received ORR Alanna Honkanen emailed her interview with DCS Tameka Fricklin she conducted via telephone on 05/06/2021 regarding the allegations.
05/12/2021	Contact - Telephone call received ORR Alanna Honkanen called for an update on the status of the investigation.
05/25/2021	Exit Conference I conducted the exit conference with licensee Lisa Murrell with my findings.

ALLEGATION:

Incident report (IR) received dated 04/18/2021 at 9AM stated Resident A fell out of his wheelchair while being transferred into bed. Resident A complained of leg and heel pain. Direct care staff (DCS) gave Resident A Tylenol. Resident A was taken via ambulance to the hospital on 04/19/2021. Resident A had a fractured right leg.

INVESTIGATION:

On 04/19/2021, intake 178960 was assigned per two separate incident reports (IR) received from CLC Farmington Freedom regarding Resident A falling out of his wheelchair on 04/18/2021, but medical treatment was not sought until 04/19/2021. Resident A’s fall resulted in a fractured right leg.

On 04/19/2021, I made a referral to Adult Protective Services (APS) and Oakland County Office of Recipient Rights (ORR). Alanna Honkanen with ORR is investigating these allegations.

On 04/21/2021, I conducted an unannounced on-site investigation. I interviewed the home manager Arleen Davis, the medication coordinator Donella Harris, Residents A

and B and then reviewed the HCC, staff communication log and Resident A's scripts for his wheelchair. Resident A was in the wheelchair and his right leg was wrapped. He was interviewed regarding the allegations. Resident A stated, "Megan was holding my wheelchair and then she let go and I went down. My ankle is broken." Later I learned from the medication coordinator Donella Harris that Tameka Fricklin goes by Megan. Resident A then said, "She tried to help me get up but was having a hard time. The paramedics helped me up." He then stated, "She gave my Tylenol, but it still hurts. I told her it still hurts."

I interviewed the medication coordinator Donella Harris regarding the allegations. Ms. Harris has worked for this corporation over 12 years. She works the day shift; 6AM-2PM. Ms. Harris stated she received a telephone call on 04/18/2021 around 5:13PM from Ms. Fricklin saying that Resident A "slipped," as she was transferring him from his wheelchair into his bed. Ms. Harris stated she asked Ms. Fricklin, "Did he fall?" Ms. Fricklin replied, "No, he slid." Ms. Fricklin then told Ms. Harris she conducted a full body scan and there were no cuts or bruises, and that Resident A was "fine." Ms. Harris stated she told Ms. Fricklin to advise Resident A that if he was not better, then Ms. Harris would take him to urgent care during her shift on 04/19/2021. Ms. Fricklin left her afternoon shift and then direct care staff (DCS) Felicia Todd began her midnight shift; 10PM-6AM. Ms. Harris stated she arrived at 6AM on 04/19/2021 and was advised by Ms. Todd that Resident A complained all night about pain. Ms. Harris then went into her office and found an IR sitting on the floor that was written by Ms. Fricklin. Ms. Harris stated she read the IR and told Ms. Todd that the IR was not consistent with what Ms. Fricklin reported to Ms. Harris. Ms. Todd told Ms. Harris, "I don't know anything about that." Ms. Harris then went into Resident A's bedroom and saw that Resident A was awake in bed holding his right leg that he had propped up with his blanket. Resident A told Ms. Harris, "Did you hear what happened to me?" Ms. Harris answered, "Tameka told me you slid." He stated, "No, I fell in the shower and Resident B picked me up and put me in bed." Ms. Harris stated she observed Resident A's leg and it was bruised and swollen. She described it as "looking deformed." Ms. Harris stated that Resident A was soiled, so she cleaned him up and then called 911. Resident A was transported to the hospital. Ms. Harris stated as she left Resident A's bedroom, Resident B called Ms. Harris to his bedroom. Resident B told Ms. Harris, "I picked Resident A up off the floor. Resident A fell between his wheelchair and his bed. I helped Tameka pick him up and place him back in the wheelchair." Resident B then told Ms. Harris that afterwards, Resident A wheeled himself back to the activities room and that Resident B heard Resident A complain that "his leg was hurting." Ms. Harris stated if she would have been told by Ms. Fricklin that Resident A fell, then she would have told Ms. Fricklin to call 911 immediately and not to wait for Ms. Harris to take him the next day if he was not better. Ms. Harris was unable to locate a script for Resident A's wheelchair but did find a script written by Resident A's doctor in 2019 for a walker only and not a wheelchair. Ms. Harris stated Resident A began using the wheelchair last year inside the facility after being discharged from rehab after both knee replacements. Ms. Harris stated she thought he had a wheelchair script, but she was unable to locate it. She stated that Resident A's sister purchased an easy glider for Resident A to assist staff in transferring Resident A, but that there is no script for the easy glider.

I interviewed the home manager Arleen Davis regarding the allegations. Ms. Davis has worked for this corporation for 16 years and nine of those years she has been the home manager at Farmington Freedom. Ms. Davis was on vacation when the incident occurred with Resident A. She stated she read the HCC and the IRs when she returned from vacation. She stated there were inconsistencies with the reporting because there was no mention that Resident B assisted Ms. Fricklin in picking Resident A off the floor after he fell even though it was reported to Ms. Davis by the medication coordinator, Ms. Harris. Ms. Davis stated she spoke with Resident B who told Ms. Davis that Resident B was in his own bedroom and he never helped Ms. Fricklin pick up Resident A off the floor. Ms. Fricklin reported to Ms. Davis that Ms. Fricklin was unsure where Resident A fell, but that Ms. Fricklin called Ms. Harris after Resident A fell telling Ms. Harris that he fell. Ms. Fricklin reported to Ms. Davis that Ms. Fricklin did not know where Resident A fell, in the shower or in his bedroom. Ms. Davis asked Ms. Fricklin, "Why didn't you call 911?" Ms. Fricklin said, "I called Donella (Ms. Harris) and told her that Resident A fell, but Donella did not feel that Resident A needed to go to the hospital. Donella said Resident A will be ok and that Donella will take him to urgent care tomorrow morning after she gets in." Ms. Fricklin told Ms. Davis that she told Ms. Harris that Resident A fell on his leg. Ms. Davis stated Resident A has been utilizing the wheelchair for a while since his return from rehab, but there is no script written by Resident A's physician for the wheelchair. Ms. Davis stated the medication coordinator would be the person who is responsible for providing direction to staff as to calling 911 for residents. She stated that Resident A should have been taken to the hospital after falling on his leg.

I reviewed the HCC dated 04/18/2021 written by DCS Tameka Fricklin that stated that Resident A was given a shower and that "he slid down out of his wheelchair on his right knee, leg trying to transfer into his bed. He stated it hurts. Staff did a body check and gave him two Tylenol for the pain. He also stated his knee gone out and his back of his foot hurts." Note: The HCC written by Ms. Fricklin never stated that Resident A fell, only that Resident A "slid," as she reported to the medication coordinator Donella Harris.
I interviewed Resident B regarding the allegations. Resident B was present in the facility but did not see Resident A fall. He stated Resident A hit his right leg on the rail where the footrest was. He knows this because after Resident A slid off his wheelchair, Resident B grabbed one side of Resident A's arm while Ms. Fricklin grabbed the other side. Resident B stated, "It takes two people to put Resident A back into his wheelchair." Resident B stated he asked Resident A, "Can you put your leg down and Resident A stated, no I can't." Resident B stated that Ms. Fricklin asked Resident B to help her pick Resident A up off the floor. Resident B stated Resident A was "in so much pain, but no one called 911." He stated that Ms. Fricklin left her shift and then Felicia Todd arrived for her shift. He stated that Resident A kept complaining that "his leg was hurting," but no one helped him until Monday, when Ms. Harris arrived at her shift. He stated that Resident A could not put his leg down because he was in too much pain.

On 04/20/2021, ORR Alanna Honkanen emailed Resident A's IPOS/Crisis plan completed by MORC. The Crisis Plan documents Resident A's unsteady gate and use of a walker, but the wheelchair is only mentioned for use in the community for long

distances. These documents do specify that he requires staff 24 hour shared supports (no specific number of staff noted) and monitoring for health and safety. He also needs assistance with monitoring health and scheduling and attending medical appointments. In addition, Ms. Honkanen was provided with the policy as to seeking medical treatment. “The policy states: The home manager/DCS will be responsible for the following: 1. Any medical situation that cannot be handled by first aid, home manager/DCS will immediately call 911…if a home has only one staff on duty, then the ill consumer should be placed into the ambulance and ambulance staff should be informed that a staff person will meet a consumer at the hospital.”

On 04/20/2021, ORR Alanna Honkanen emailed her interview with Resident A’s support’s coordinator, Maureen McGurn. The following is her interview:

> “Resident A is not prone to injury. However, staff do complete visual checks hourly to ensure he is monitored for health and safety. She noted that one staff on shift at any given time is "still appropriate." She received the incident report (IR) regarding the fall. She did not have concerns about the fall itself, per-se. She noted that Resident A can (and does) transfer himself (without staff assistance) from his wheelchair to the bed/chair, etc. as needed and that there have been no reports of issues with this. She reported that Resident A recently had pneumonia and was hospitalized with pneumonia on 02/18/2021 and he then went to rehab on 02/23/2021 and was discharged on 03/10/2021. She reported that Resident A uses a walker to ambulate, but that recently, he has been using his wheelchair more and more as he feels more comfortable getting around this way. She noted that she will update his crisis plan to reflect this. The home manager shared concerns regarding the staff's delay in getting Resident A medical care. She noted that she was also concerned because the IRs seemed incomplete or inconsistent. She noted that when she spoke with Resident A, he reported that when he fell, his roommate Resident B had to pick him up to help him on his bed. She said she spoke with Resident B who also confirmed this. The IR notes nothing about this detail.”

On 04/22/2021, I received a voice mail message from APS worker, Marcie Fincher stating she is investigating these allegations.

On 05/03/2021, I emailed APS worker Marcie Fincher the staff communication log stating on 04/18/2021, Ms. Fincher documented that on 04/18/2021, Resident A complained of pain, but did not communicate with word where the pain was. I also emailed her the script written by Resident A’s physician Dr. Anthony Munaco on 08/21/2019 stated: Evaluated today, recommend use of wheeled walker for ambulation. No regular use of wheelchair.

On 05/10/2021, I interviewed DCS Felicia Todd via telephone regarding the allegations. Ms. Todd has been working for this corporation for six years. She usually works the midnight shift; 10PM-6AM. Ms. Todd stated there is usually two staff per shift, but recently they have been understaffed. On 04/18/2021, she arrived to begin her shift and

DCS Tameka Fricklin was ending her shift. Ms. Fricklin told Ms. Todd that Resident A fell and Ms. Fricklin called the medication coordinator Donella Harris twice regarding the fall. Ms. Fricklin told Ms. Todd that Ms. Harris instructed her to watch and observe Resident A and if he complained of pain, to give Resident A pain medication. Ms. Fricklin told Ms. Todd she gave Resident A Tylenol. Ms. Todd stated she was making her rounds at 4AM and went into Resident A's bedroom. She stated Resident A was making "grunting sounds." Ms. Todd asked, "what's wrong? Are you in any pain," but Resident A did not respond? Ms. Todd stated Resident A's blanket was off him, but she did not notice his right leg from where she was standing from the entrance as she was only able to see his left leg which did not appear injured. She left his room and then returned at 4:30PM and he was asleep. At 6AM, the medication coordinator Donella Harris arrived at the home. Ms. Harris went to her office and found the IR on the floor. Ms. Harris read the IR and told Ms. Todd, "This is not what was told to me by Tamika. Tamika told me he slid, not fell." Ms. Todd told Ms. Harris, "I don't know what was told to you, but this is what happened during my shift. Resident A was making grunting sounds but would not respond when I asked him if he was in pain." Ms. Harris told Ms. Todd that Resident A had been making grunting noises since ever since he received his Covid-19 vaccine. Ms. Todd left her shift but then when she returned the next day, she was told by Ms. Harris that Resident A had a fracture and that his leg was "deformed." Ms. Todd stated she did not observe the right leg during her shift and that if she would have observed it or been told by Ms. Fricklin how Resident A fell, she would have contacted 911 immediately. Ms. Fricklin stated she was not provided with all the information. She stated she saw Resident A the next day and Resident A told Ms. Todd, "I'm much better now." Ms. Todd stated that Resident A never complained of any leg pain to her during her shift. She stated that when she had arrived at her shift on 04/18/2021, Resident B was in his bedroom with his door closed so she assumed he was asleep. Ms. Todd stated that Resident A began using the wheelchair regularly after being discharged from rehab. She too has not seen the script written by Resident A's physician for the wheelchair. Ms. Todd stated she wants to make it clear that she has been doing direct care work for years and that she knows the process and these consumers so if she would have been given all the information, she would have contacted 911 immediately. Ms. Todd was advised that according to the HCC written by Ms. Harris, Resident A was verbal when Ms. Harris spoke with him the morning of 04/19/2021 and that Ms. Harris found Resident A soiled during Ms. Todd's shift. Ms. Todd stated she spoke with Ms. Harris about what she wrote and stated, "Resident A was not soiled, and he never complained of leg pain to me. What Ms. Harris wrote is incorrect and I told her this."

On 05/10/2021, I interviewed Resident A's supports coordinator Maureen McGurn with MORC. Ms. McGurn stated she was provided a couple of explanations as to how Resident A fell. She was first told that Resident B helped Resident A get into bed and then told that Ms. Fricklin helped Resident A into bed. Ms. McGurn thinks that Resident A fell in his bedroom while being transferred from his wheelchair to his bed. Resident A's IPOS/Crisis Plan only stated that the wheelchair was to be utilized while Resident A was out in the community, not in the home; however, the IPOS/Crisis Plan has been updated to reflect that Resident A uses the wheelchair and not the walker in the home.

On 05/12/2021, I received a return call from ORR Alanna Honkanen. Ms. Honkanen stated she interviewed DCS Tameka Fricklin and will email the interview. She also stated that based on her investigation, she will be substantiating her case.

On 05/12/2021, ORR Alanna Honkanen emailed her interview with DCS Tameka Fricklin and here is the interview:

> "Interview conducted on 05/06/2021 with DCS, Tameka Fricklin. On the day of the incident in question, Resident A had just gotten out of the shower and was in the process of getting dressed. Resident A was in his bedroom, sitting in his wheelchair with a t-shirt on, but not bottoms. Tameka was getting ready to assist Resident A with transferring to his bed, to finish helping him get dressed. As Resident A sat in his wheelchair, facing the bed, he reached out to try and transfer himself. Tameka stated, "I told him to wait, so I can get the glider", but noted, "he can't hear well" and that "he reached out and tried to grab the bed rail and slid down". Tameka indicated that at that point, Resident A, "slid out of his chair and onto the floor." Tameka reported that when Resident A slid to the floor, he landed on his knees. Tameka stated, "I got him back up, back into his chair. Then got him back into bed". Tameka added, "I did a body check. I checked his whole body. There were no abrasions, cuts, bruising. He said he was ok at that time", noting it to be "between 12:30 and 1:00 (p.m.)" when Resident A fell. Tameka noted that Resident A already has two implants in his leg, which give the appearance of a deformity, but noted that she saw nothing else unusual, adding, "no discoloration, no apparent signs of injury." Tameka reported that she then continued to assist Resident A getting dressed. Tameka noted that as she helped Resident A get his pants on, he didn't say anything about his leg hurting. Tameka reported that "about an hour or two later" Resident A "got back in his wheelchair and came to the dinner table" noting "that's when he said his leg hurt". Per Tameka, it was at this point that Resident A said that he was in pain, adding, "he said ouch, my leg hurts. He pointed at his leg between his knee and his ankle." Tameka reported: "I gave him some Tylenol and called the Medical Coordinator". I told Donella that he fell, that I gave him Tylenol and that I was doing a report. She said, 'is he alright?' I said, well he fell. I'm not a doctor. So, I can't tell. The way his legs crossed on the floor; he could be injured. She said, 'well he can go to the doctor tomorrow when she come to work'. I told her he said he's in pain and that I gave him Tylenol". Tameka reported that after dinner, Resident A went back into his room, ate a bag of skittles, and watched television. She noted that she helped Resident A get back into bed at around 8:30 p.m. and that he did not say anything about his leg hurting at that time. Tameka reported that she then left her shift at 10:00 p.m., she gave Resident A some Tylenol again, adding, "he seemed fine. He was getting ready to go to bed". Tameka reported that when her replacement, Felicia arrived she, "told her that he fell, that I gave him Tylenol and did a report, that I talked to the medical coordinator and that she said she'd take him to the doctor in the morning." Tameka added that Resident A was not walking around that day, so she did not observe him to be limping, etc. Tameka

noted that Resident A had been using a wheelchair all day for quite some time and that he generally utilized the wheelchair as opposed to a walker. Tameka reported that in her experience, when an individual falls or injures themselves, the medical coordinator "is supposed to come in and take him to the doctors" adding that there are "no other instructions" or staff expectations in this area.”

On 05/25/2021, I conducted the exit conference via telephone with licensee designee Lisa Murrell with my findings. Ms. Murrell stated CLC Farmington Freedom attempted to get the script for Resident A’s wheelchair and glider from the physician, but the physician had retired and then there was an issue with Resident A’s health insurance; however, will be getting the script for both assistive devices. Ms. Murrell agreed to submit a corrective action plan.

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the authorization.
ANALYSIS:	Based on my investigation and information gathered, Resident A did not have in writing authorization for the use of the wheelchair and glider by his licensed physician. According to the script dated 08/21/2019 by Dr. Anthony Munaco, a wheeled walker was prescribed, not a wheelchair or glider. In addition, Resident A’s IPOS/Crisis Plan dated 07/24/2020 documented Resident A’s unsteady gate and the use of a walker, but the wheelchair is only mentioned for use in the community for long distances.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.

ANALYSIS:	Based on my investigation and information gathered, DCS Tameka Fricklin did not seek immediate care for Resident A after he fell on 04/18/2021. According to the HCC documented by Ms. Fricklin on 04/18/2021, Resident A slid out of his wheelchair onto his right leg and then complained of pain. Resident A was complaining of leg pain all through the day and night but no DCS contacted the ambulance until 04/19/2021 when the medication coordinator Donella Harris arrived at the facility. Resident A sustained a fractured right leg because of the fall. According to CLC's policy, 911 is contacted immediately if any medical situation cannot be handled by first aid; therefore, DCS Ms. Fricklin should have contacted 911 immediately after Resident A fell and his situation was not handled by first aid.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receiving an acceptable corrective action plan, I recommend this special investigation be closed and no change to the status of the license.

05/25/2021

Frodet Dawisha — Date
Licensing Consultant

Approved By:

05/25/2021

Ardra Hunter — Date
Area Manager