GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 26, 2021

Paula Ott
Central State Community Services, Inc.
Suite 201
2603 W Wackerly Rd
Midland, MI 48640

RE: License #: AS250010981
Investigation #: 2021A0501024
Parkside FAIS

Dear Ms. Ott:

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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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 (810) 787-7031.

Sincerely,

Crecendra Brown

Crecendra Brown, Licensing Consultant
Bureau of Community and Health Systems
4809 Clio Road
Flint, MI 48504
(810) 931-0965

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250010981
Investigation #:	2021A0501024
Complaint Receipt Date:	04/15/2021
Investigation Initiation Date:	04/15/2021
Report Due Date:	06/14/2021
Licensee Name:	Central State Community Services, Inc.
Licensee Address:	Suite 201 2603 W Wackerly Rd Midland, MI 48640
Licensee Telephone #:	(989) 631-6691
Administrator:	Allison Gould
Licensee Designee:	Paula Ott
Name of Facility:	Parkside FAIS
Facility Address:	8358 Neff Rd Mt Morris, MI 48458
Facility Telephone #:	(810) 687-7751
Original Issuance Date:	03/04/1993
License Status:	REGULAR
Effective Date:	02/15/2021
Expiration Date:	02/14/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On April 7, 2021, AFC home staff fed Resident A a sandwich, even though he had problems with swallowing, and Resident A choked on the sandwich. Resident A was sent to the hospital and died on April 13, 2021.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/15/2021	Special Investigation Intake 2021A0501024
04/15/2021	Special Investigation Initiated - Letter
04/15/2021	APS Referral Genesee County Adult Protective Services Kelly Clark-Huey.
04/15/2021	Contact - Document Sent Requested paperwork in regard to the investigation from Licensee Designee Paula Ott and Program Coordinator Brett Perhase.
04/20/2021	Contact - Document Received Received Resident A's physician information, weight record, physician orders, standing orders, case manager information, incident report, staff phone numbers, and facility resident register.
05/11/2021	Contact - Telephone call made. Guardian A.
05/12/2021	Inspection Completed On-site Staff Cierra Tillis, Staff Kendria Battle, Resident B, Resident C, and Resident D.
05/13/2021	Contact - Telephone call made. Staff Myisha Hill.
05/13/2021	Contact - Telephone call made. Program Coordinator Brett Perhase.
05/13/2021	Contact - Telephone call made. Case Manager Sally Birchmeier.

05/13/2021	Contact - Telephone call made. Dr. Phung.
05/13/2021	Exit Conference Administrator Allison Gould.
05/14/2021	Contact - Telephone call received. Administrator Allison Gould.
05/18/2021	Contact – Document received Genesee Health System Recipient Rights Investigation Summary Report.

ALLEGATION:

On April 7, 2021, AFC home staff fed Resident A a sandwich, even though he had problems with swallowing, and Resident A choked on the sandwich. Resident A was sent to the hospital and died on April 13, 2021.

INVESTIGATION:

On April 15, 2021, I sent an email to Licensee Designee Paula Ott and Program Coordinator Brett Perhase requesting paperwork in regard to the special investigation. I requested a copy of Resident A's resident care agreement, assessment plan, health care appraisal, weight record, physician orders, special diets, and incident reports.

On April 20, 2021, I received Resident A's physician information, weight record, physician orders, standing orders, case manager information, incident report, staff phone numbers, and facility resident register. Resident A's weight record shows that he started losing weight every month from September 2019 to March 2021. Resident A weighed 176 pounds in September 2019 and he weighed 135 pounds in March 2021. Incident report dated April 7, 2021 involves Resident A, Program Coordinator Brett Perhase, Administrator Allison Gould, Staff Kendria Battle, and Staff Myisha Hill. The incident report states that Staff Kendria Battle was in the dining room, Staff Myisha Hill was in the bathroom giving a resident a shower, Program Coordinator Brett Perhase and Administrator Allison Gould was in the front room of the AFC home. Resident A was at the dining table eating when all of a sudden everyone heard a big bang. Resident A had fell on the floor. Resident A was unresponsive, and staff noticed that he had food in his mouth. Mr. Perhase called 911, Ms. Gould tried to dislodge the food in Resident A's mouth and Mr. Perhase tried to perform CPR on Resident A. When EMS arrived, they performed an emergency tracheotomy on Resident A and gave him multiple injections of epinephrine. Resident A was taken to Hurley hospital and was still unresponsive. Resident A's standing orders from Dr. Phung dated January 27, 2021 state that he is to have clear liquids and foods that are liquid at room temperature.

Provided examples were milk, milk drinks, strained cream soups, yogurt without fruit or seeds, custard, pudding, ice cream, and all fruit juices.

On May 11, 2021, I conducted a phone interview with Guardian A. Guardian A stated that the allegation was true. Guardian A stated that Resident A was having problems swallowing and had not had a swallowing test yet. Guardian A stated that Resident A had marks on his face from falling out of the chair onto the floor when he was choking. Guardian A stated that the Program Coordinator Brett Perhase called her and told her that Resident A was on his way to the hospital on April 7, 2021 because he had choked on some food. Guardian A stated that Resident A was supposed to be in line-of-sight supervision and he was supposed to be watched while he was eating. Guardian A stated that she does not believe staff were watching him while he was eating. Guardian A stated that Resident A had pica and the home staff knew that he had problems swallowing lately. Guardian A stated that she went out to the AFC home on April 13, 2021 to get some of Resident A's things. Guardian A stated that the home staff were trying to get her to sign a resident care agreement and assessment that she had never seen before. Guardian A stated that she refused to sign it and she was not given a copy of anything. Guardian A stated that Resident A suffered his last days in the hospital and never regained consciousness. Guardian A stated that she feels as though the AFC home staff was neglectful and Resident A's death could have been prevented. Guardian A stated that Resident A developed sepsis from the food in his lungs and he died April 13, 2021.

On May 12, 2021, I conducted an unannounced onsite investigation at Parkside AFC home. Staff Cierra Tillis, Staff Kendria Battle, Resident B, Resident C, and Resident D were interviewed.

Staff Cierra Tillis stated that she was not at the home on April 7, 2021. Ms. Tillis stated that she did not start working at the home until after the incident happened. Ms. Tillis stated that she fills in on different shifts at several Central State homes. Ms. Tillis stated that she had worked with Resident A in the past. Ms. Tillis stated that she did not know anything about Resident A having a swallowing problem. Ms. Tillis stated that she did not know anything about Resident A being in line-of-sight supervision. Ms. Tillis stated that she did not know anything about Resident A's special diets. Ms. Tillis stated that Resident A's food was supposed to be prepared a certain way, but she could not remember the specifics.

Staff Kendria Battle stated that on April 7, 2021 Resident A was sitting down at the table eating and she sat down with him for a little bit. Ms. Battle stated that she stepped away from Resident A for a minute to talk to Program Coordinator Brett Perhase and Administrator Allison Gould. Ms. Battle stated that she heard Resident A fall on the floor. Ms. Battle stated that when she looked at Resident A, he was blue. Ms. Battle stated that Mr. Perhase started CPR on Resident A and they called 911. Ms. Battle stated that Resident A was taken to the hospital. Ms. Battle stated that Resident A was eating a bite size sandwich that was cut up. Ms. Battle stated that all of Resident A's food had to be cut up in bite size pieces. Ms. Battle stated that Resident A did have

pica and would eat almost anything, but staff would check his mouth before he started eating. Ms. Battle stated that staff were to stay with Resident A the entire time when he ate because he was known to eat too fast. Ms. Battle stated that she does not know if Resident A had a swallowing problem.

Resident B, Resident C, and Resident D were all clean. Resident B and Resident C are nonverbal. Resident D was in his room resting and stated that he was doing good. The AFC home was clean and the residents were all content. Resident E was gone to an appointment and not at the home during my onsite inspection. Resident B, Resident C, and Resident D had no visible marks or bruises.

On May 13, 2021, I conducted a phone interview with Staff Myisha Hill. Staff Myisha Hill stated that on April 7, 2021 she was in the back of Parkside AFC home giving a resident a shower. Ms. Hill stated that Resident A was at the dining room table eating a ham sandwich and it was cut into bite size pieces. Ms. Hill stated that staff are to stay at the table with Resident A while he eats to make sure he does not choke. Ms. Hill stated that she does not know if Staff Kendria Battle was at the table or not.

On May 13, 2021, I conducted a phone interview with Program Coordinator Brett Perhase. Program Coordinator Brett Perhase stated that on April 7, 2021 hew was sitting in the front room with Administrator Allison Gould and heard a boom. Mr. Perhase stated that Resident A was on the dining room floor and Staff Kendria Battle was in the kitchen. Mr. Perhase stated that he started CPR and EMS came in minutes. Mr. Perhase stated that EMS worked on Resident A for a while and then rushed him to the hospital with a pulse. Mr. Perhase stated that he never knew of Resident A choking before. Mr. Perhase stated that staff are supposed to stay at the table with Resident A while he eats to make sure he does not choke. Mr. Perhase stated that while Resident A was eating, Staff Battle was in the kitchen and Staff Hill was in the back assisting another resident.

On May 13, 2021, I conducted a phone interview with Case Manager Sally Birchmeier. Case Manager Sally Birchmeier stated that Resident A was on a safe eating plan and staff were to cut his food up into tiny pieces. Ms. Birchmeier stated that she does not know if Resident A was having difficulty swallowing. Ms. Birchmeier stated that Resident A had a history of extreme pica and he often had something in his mouth trying to eat it. Ms. Birchmeier stated that staff were supposed to be with Resident A at the table while he was eating. Ms. Birchmeier stated that Resident A's occupational therapy plan was given to the AFC home and it states that the staffs are to stay at the table while Resident A ate food and his food was to be cut into bite size pieces.

On May 13, 2021, I tried to contact Dr. Phung at Genesee Community Health Center. I left a message for him to call me back with the front desk receptionist. On May 18, 2021, Dr. Phung returned my phone call. Dr. Phung stated that Resident A was his patient, but he had no control over his special diet. Dr. Phung stated that he did not know if Resident A had pica and had no indication of him having a swallowing problem. Dr. Phung stated that Resident A was capable of limited communication and the last

time he saw him was March 2021. Dr. Phung stated that Resident A had lost weight, but it was not significant. Dr. Phung stated that Guardian A was concerned about Resident A's loss of appetite and weight loss. Dr. Phung stated that he informed Resident A's caregiver that they needed to check into a medication change for Resident A and feeding him more frequently throughout the day.

On May 14, 2021, I received a phone call from Administrator Allison Gould. Ms. Gould stated that she sent me a copy of Resident A's resident care agreement and assessment plan. I reviewed the resident care agreement. The resident care agreement was dated December 30, 2020, it did not have Guardian A's signature and it did not have the Administrator's or Licensee Designee's signature. The administrator for the home during that time was Brittany Johnson. I reviewed the assessment plan. The assessment plan was dated December 30, 2020. The assessment plan stated that Resident A did not need assistance with eating or feeding, but he was on a special diet for staff administering bite size food. The assessment plan did not have Guardian A's signature and it did not have the Administrator or Licensee Designee's signature.

On May 18, 2021, I reviewed the Genesee Health System Recipient Rights Investigation Summary Report. Resident A's Individual Plan of Service had multiple standards of care to help prevent Resident A from choking. Staff were to monitor Resident A's chewing, the size of his bites, the frequency of his bites, his swallowing, and staff were to encourage him to take drinks in between bites. Resident A's occupational therapy treatment plan dated October 1, 2020 stated that staff were to sit or stand directly at the table while Resident A ate to provide verbal and touch prompts to promote safe eating. Staff were to make sure Resident A chewed well and swallowed before taking another bite of food. Staff needed to encourage Resident A to take a sip of his drink during his eating after 3 to 4 bites. The Genesee Health System Recipient Rights Investigation Summary Report concluded that the staff were neglectful, failed to follow Resident A's Individual Plan of Service which led to him choking and his subsequent death. Staff Kendria Battle's employment with Central State Community Services, Inc. was terminated on May 17, 2021.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	Resident A' assessment plan stated that staff were to help with the administration of Resident A's special diet of bite size food. Resident A's Individual Plan of Service stated that Staff were to monitor Resident A's chewing, the size of his bites, the frequency of his bites, his swallowing, and staff were to encourage him to take drinks in between bites. Resident A's occupational therapy treatment plan dated October 1, 2020 stated that staff were to sit or stand directly at the table while Resident A ate to provide verbal and touch prompts to promote safe eating. Staff were to make sure Resident A chewed well and swallowed before taking another bite of food. Staff needed to encourage Resident A to take a sip of his drink during his eating after 3 to 4 bites. Staff Kendria Battle, Program Coordinator Brett Perhase, and Administrator Allison Gould stated that on April 7, 2021 Staff Kendria Battle stepped away from the dining room table while Resident A was eating. Resident A choked and fell on the floor unresponsive. Resident A passed away on April 13, 2021.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On April 15, 2021, I sent an email to Licensee Designee Paula Ott and Program Coordinator Brett Perhase requesting paperwork regarding the special investigation. I requested a copy of Resident A's resident care agreement, assessment plan, health care appraisal, weight record, physician orders, special diets, and incident reports.

On April 20, 2021, I received Resident A's physician information, weight record, physician orders, standing orders, case manager information, incident report, staff phone numbers, and facility resident register. I did not receive Resident A's assessment plan, resident care agreement and health care appraisal.

On May 13, 2021, I conducted a phone exit conference with Administrator Allison Gould. I informed Administrator Allison Gould that I would be recommending a provisional license due to severity of the violations identified in the report and the repeat violations. Ms. Gould stated that she would fax me the missing paperwork today.

On May 14, 2021, I received a phone call from Administrator Allison Gould. Ms. Gould stated that she sent me a copy of Resident A's resident care agreement and

assessment plan. Ms. Gould stated that she did not send me a copy of the health care appraisal because the last one on file is dated January 10, 2019. Ms. Gould stated that she would be putting her focus on Parkside as the new administrator and putting a corrective action plan in place to get the home back on the right track. I reviewed the resident care agreement. The resident care agreement was dated December 30, 2020, it did not have Guardian A's signature and it did not have the Administrator's or Licensee Designee's signature. The administrator for the home during that time was Brittany Johnson. I reviewed the assessment plan. The assessment plan was dated December 30, 2020. The assessment plan stated that Resident A did not need assistance with eating or feeding, but he was on a special diet for staff administering bite size food. The assessment plan did not have Guardian A's signature and it did not have the Administrator or Licensee Designee's signature.

In Special Investigation 2019A0501021 dated May 1, 2019, Rule 400.14310(3)(4) was cited as a violation due to the fact that the resident had lost a significant amount of weight, was taken to Hurley Hospital, and diagnosed with failure to thrive. Staff at the AFC home noticed that the resident had not been eating and losing weight but waited to send the resident to the hospital. The AFC home failed to obtain immediate medical care for the resident. Rule 400.14301(4) was cited as a violation due to the resident's file being missing when I conducted an onsite inspection, the resident assessment plan that was provided to me did not have the guardian's signature, the licensee designee's signature, or the administrator's signature. Rule 400.14301(6)(8) was cited as a violation due to the resident care agreement not being signed by the licensee designee or the administrator and the missing resident record.

Corrective action plan dated May 17, 2019 and signed by Licensee Designee Paula Ott for Special Investigation Report #2019A0501021 states that resident weight records will be kept up to date and when significant changes are noticed they will immediately contact a health care provider. Management will make sure all resident records are on file in the home. Management will make sure all paperwork is signed and up to date.

In Special Investigation 2020A0501006 dated December 27, 2019, Rule 400.14314(1)(2)(3) was cited as a violation due to the resident's toe nails, fingernails and facial hair being extremely long. Staff were not attending to the resident's grooming and personal hygiene. The resident's assessment plan stated that he was to be assisted by staff with his grooming and personal hygiene. Rule 400.14301(4) was cited as a violation due to the resident's assessment plan not having the Administrator's or Licensee Designee's signature. Rule 400.14301(6)(8) was cited as violation due to the resident's resident care agreement not having the Administrator's or Licensee Designee's signature and the resident care agreement not being maintained in the resident's record when I went out to the home for the onsite.

Corrective action plan dated January 10, 2020 and signed by Licensee Designee Paula Ott for Special Investigation Report #2020A0501006 states that the resident's grooming and hygiene would be attended to weekly. Resident paperwork had been signed by the administrator and sent out to the guardians for their signatures.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	I reviewed Resident A's assessment plan. Resident A's assessment plan was dated December 30, 2020. The assessment plan did not have Guardian A's signature and it did not have the Administrator or Licensee Designee's signature.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Special Investigation 2019A0501021 dated May 1, 2019.** **Special Investigation 2020A0501006 dated December 27, 2019.**

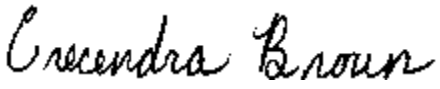
APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. **(8) A copy of the signed resident care agreement shall be provided to the resident or the resident's designated representative. A copy of the resident care agreement shall be maintained in the resident's record.**

ANALYSIS:	I reviewed Resident A's resident care agreement. Resident A's resident care agreement was dated December 30, 2020, it did not have Guardian A's signature and it did not have the Administrator's or Licensee Designee's signature. The administrator for the home during that time was Brittany Johnson.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Special Investigation 2019A0501021 dated May 1, 2019.** **Special Investigation 2020A0501006 dated December 27, 2019.**

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	On April 15, 2021, I sent an email to Licensee Designee Paula Ott and Program Coordinator Brett Perhase requesting a copy of Resident A's health care appraisal. On May 14, 2021, I received a phone call from Administrator Allison Gould. Ms. Gould stated that she did not send me a copy of the health care appraisal because the last one on file is dated January 10, 2019.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

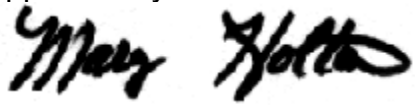
Upon the receipt of an acceptable and approved corrective action plan, a provisional license is recommended.



May 26, 2021

Crecendra Brown — Date
Licensing Consultant

Approved By:



May 26, 2021

Mary E Holton — Date
Area Manager