STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

July 6, 2021

Ann Meldrum
Samaritas
8131 East Jefferson Avenue
Detroit, MI 48214-2691

RE: License #: AS530311992
Investigation #: 2021A0230026
Home of Scottville - Main Street

Dear Ms. Meldrum:

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 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 (231) 922-5309.

Sincerely,

Rhonda Richards, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 342-4942

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS530311992
Investigation #:	2021A0230026
Complaint Receipt Date:	06/22/2021
Investigation Initiation Date:	06/22/2021
Report Due Date:	08/21/2021
Licensee Name:	Samaritas
Licensee Address:	8131 East Jefferson Avenue Detroit, MI 48214-2691
Licensee Telephone #:	(989) 832-3432
Administrator:	Ann Meldrum
Licensee Designee:	Ann Meldrum
Name of Facility:	Home of Scottville - Main Street
Facility Address:	314 North Main Street Scottville, MI 49454
Facility Telephone #:	(231) 936-1012
Original Issuance Date:	09/15/2011
License Status:	REGULAR
Effective Date:	03/20/2020
Expiration Date:	03/19/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A fell and injured head. As a result, she had a scrape on her forehead and bruises on her eye and nose. Staff did not attend to her or use head injury protocol.	Yes

III. METHODOLOGY

06/22/2021	Special Investigation Intake 2021A0230026
06/22/2021	Special Investigation Initiated - Telephone Karen Hobart-RRO
06/23/2021	Inspection Completed On-site Interview with Deb Davis-Home Manager
06/23/2021	Contact - Face to Face Observation of Resident A
06/24/2021	Contact - Telephone call made. Staff member Anna Hayes
06/24/2021	Contact - Telephone call made. Staff member Becky Cook
06/30/2021	Telephone call made – Deb Davis
06/30/2021	Exit conference -With Licensee Designee Ann Meldrum

ALLEGATION: Resident A fell and injured head. As a result, she had a scrape on her forehead and bruises on her eye and nose. Staff did not attend to her or use head injury protocol.

INVESTIGATION: On 06/23/2021, I conducted an unannounced on-site investigation at the facility and interviewed Home Manager Deb Davis. Present for the interview was Karen Hobart from Community Mental Health Recipient Rights Office. I observed Resident A in her bed but was unable to interview her due to cognitive limitations. She had a large scrape across her forehead and bruised eye and nose.

Ms. Davis stated that staff member Becky Cook informed her that she was taking residents on an outing on 06/15/2021 and prior to leaving and getting in the van

Resident A fell out of her wheelchair and hit her head. Ms. Cook continued to get Resident A in the van and did not check for head injury per company protocol. Ms. Davis stated she was notified by another staff member at 4:30 p.m. when Ms. Cook arrived back from the outing. At that time staff began head injury protocol.

On 06/24/2021, I spoke with staff member Anna Hayes who stated that she worked with staff member Becky Cook on 06/15/2021. At 3:15 p.m. Ms. Cook left to take three residents on an outing. She returned at 4:15 p.m. and when she came inside with the residents Ms. Cook stated that Resident A had fallen and hit her head. Ms. Hayes assumed it had just occurred when they returned from the outing but learned later that the incident occurred prior to the group outing. Ms. Cook got Resident A inside and head injury protocol was completed, and the home manager was called. Ms. Hayes noted a scrape to Resident A's forehead and later bruising on her eye and nose. Ms. Hayes stated head injury protocol includes monitoring vital signs every hour for the first four hours after the injury then every four hours for the remainder of the 24-hour period in addition to noting if a resident if vomiting, bleeding or loss of consciousness. Ms. Hayes stated the protocol instructions are placed throughout the facility and it is common knowledge on what to do if a resident hits their head.

On 06/24/2021, I spoke with staff member Becky Cook regarding the above allegation. She acknowledged that she had taken three residents on an outing on 06/15/2021. While she was going to turn on the van Resident A was in her wheelchair right next to the van when a gust of wind came up and she toppled out of her wheelchair onto the grass. She stated she then helped Resident A up off the grass and into the van and continued on the outing. She arrived back at the facility an hour later. Ms. Cook stated; "I'll admit I looked at her, saw the scrape, and she seemed okay. I should have gone inside with her and started head injury protocol." She stated, "I just wasn't thinking I guess." Ms. Cook stated she was well aware of the head injury protocol and had received training on the protocol.

On 06/30/2021, I spoke with Home Manager Deb Davis who stated she was having a full staff meeting that day and refresher training on head injury protocol for all staff. Additionally, she stated she would be issuing a written reprimand for Ms. Cook.

On 06/30/2021, I conducted an exit conference with Licensee Designee, Ann Meldrum and reviewed the findings of the investigation. She concurred with the findings and stated it was unfortunate that Ms. Cook did not follow protocol. She stated she will provide a plan of correction.

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:	After Resident A fell onto the grass out of her wheelchair and hit her head receiving a scrape Ms. Cook did not obtain immediate care. She did not follow head injury protocol. Instead she continued on with the outing did not notify anyone until an hour later when returning from the outing.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction I recommend the license remain unchanged.

07/01/2021

Rhonda Richards — Date
Licensing Consultant

Approved By:

07/06/2021

Jerry Hendrick — Date
Area Manager