GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 11, 2021

Jonathan Harland
Community Home & Health Services LLC
657 Chestnut Ct
Gaylord, MI 49735

RE: License #: AS690382148
Investigation #: 2021A0009041
Pinehaven Red

Dear Mr. Harland:

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,

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 350-0939

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AS690382148 |
| | |
| **Investigation #:** | 2021A0009041 |
| | |
| **Complaint Receipt Date:** | 09/15/2021 |
| | |
| **Investigation Initiation Date:** | 09/15/2021 |
| | |
| **Report Due Date:** | 10/15/2021 |
| | |
| **Licensee Name:** | Community Home & Health Services LLC |
| | |
| **Licensee Address:** | 657 Chestnut Ct<br>Gaylord, MI 49735 |
| | |
| **Licensee Telephone #:** | (989) 732-6374 |
| | |
| **Administrator:** | Jonathan Harland |
| | |
| **Licensee Designee:** | Jonathan Harland, Designee |
| | |
| **Name of Facility:** | Pinehaven Red |
| | |
| **Facility Address:** | 118 McLouth Rd<br>Gaylord, MI 49735 |
| | |
| **Facility Telephone #:** | (989) 732-1614 |
| | |
| **Original Issuance Date:** | 05/31/2016 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 07/02/2021 |
| | |
| **Expiration Date:** | 07/01/2023 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>DEVELOPMENTALLY DISABLED<br>MENTALLY ILL |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A fell on September 14, 2021 and was not taken to the hospital until the next day. He had several abrasions on his body including the front and back of his right shoulder, his eyebrow and the back of his head. He had four rib fractures to his right side. | Yes |
| Resident A and Resident B are not eating and are losing weight as a result. The staff are not mixing Resident B's Thick-It properly. | No |
| Additional Finding | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 09/15/2021 | Special Investigation Intake<br>2021A0009041 |
| 09/15/2021 | Special Investigation Initiated – Telephone call with North Country Community Mental Health (CMH) caseworker Ms. Rebecca Flint |
| 09/16/2021 | APS Referral |
| 09/20/2021 | Inspection Completed On-site<br>Interview with administrator Ms. Kris Rambo<br>Face to face with Resident A and Resident B |
| 09/22/2021 | Contact – Telephone call received from licensee designee Mr. Jonathan Harland, Community Home & Health Services |
| 09/22/2021 | Contact – Document (email) received from administrator Mr. Kris Rambo, Community Home & Health Services |
| 09/30/2021 | Contact – Telephone call made to Mr. Joshua Perri, adult protective services, left message |
| 09/30/2021 | Contact – Telephone call received from Mr. Joshua Perri, adult protective services, left message |
| 10/06/2021 | Contact – Telephone call received from administrator Ms. Kris Rambo, Community Home & Health Services |
| 10/06/2021 | Contact – Telephone call made to direct care worker Mr. Cameron Greer, Community Home & Health Services |
| 10/07/2021 | Contact – Telephone call made to North Country CMH nurse Ms. Lindsey Gaertney |

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|---|---|
| 10/08/2021 | Contact – Telephone call made to licensee designee Mr. Jonathan Harland |
| 10/08/2021 | Exit conference with licensee designee Mr. Jonathan Harland |
| 10/08/2021 | Contact – Telephone call received from administrator Ms. Kris Rambo, Community Home & Health Services |
| 10/08/2021 | Contact – Documents (texts) received from administrator Ms. Kris Rambo, Community Home & Health Services |

**ALLEGATION: Resident A fell on September 14, 2021 and was not taken to the hospital until the next day. He had several abrasions on his body including the front and back of his right shoulder, his eyebrow and the back of his head. He had four rib fractures to his right side.**

**INVESTIGATION:** I spoke with Ms. Rebecca Flint with North Country Community Mental Health (CMH) by phone on September 15, 2021. She is the caseworker for the residents who live at the Pinehaven Red adult foster care home. She reported that Resident A recently had a fall in the home and received significant injuries. Ms. Flint was not only concerned about the falls and significant injuries but also that the home had not been sending incident reports to her. In regard to Resident A's recent fall which resulted in significant injury, it took the home two full days to obtain medical care for him.

I conducted an unannounced site inspection at the Pinehaven Red adult foster care home on September 20, 2021. I wore personal protection equipment to protect myself and others. Administrator Ms. Kris Rambo was on-site and spoke with me about Resident A's fall. She said that Resident A had fallen and had significant injuries from the fall. Direct care workers Cameron Greer and Nelda Nortley had been present the morning that he fell. Ms. Rambo stated that Resident A has fallen before but never received such significant injuries from a fall. She stated he can be "wobbly" at times. I asked her about the falls not being reported to CMH. She admitted that the incident reports had not been sent to CMH as required. Ms. Rambo stated that she had recently found a stack of incident reports in the office that were supposed to be sent to CMH. The staff had told her that the reports had not been sent because the fax machine was broken. She had instructed them that the reports needed to be sent out immediately and reminded them that there is a fax machine next door (in the agency's neighboring adult foster care home). They can also call the agency's main office for assistance.

I received a call from the licensee designee, Jonathan Harland, by phone on September 22, 2021. He reported that Resident A is not a stable individual and that they are looking at their routine to minimize falls. Mr. Harland stated that Resident A has fallen before but has not been significantly injured before. Mr. Harland stated

that he is working with staff to ensure that incidents are reported to CMH every single time they are required.

I left a voicemail message for adult protective services worker Mr. Joshua Perri on September 30, 2021. He returned my message and reported that adult protective services are not investigating the matter of Resident A falling and sustaining injuries. The matter had been screened-out and not assigned for investigation.

I spoke with administrator Ms. Kris Rambo by phone on October 6, 2021. She stated that direct care worker Cameron Greer was working the day Resident A fell. He was available for me to speak to later that day. She reported that direct care worker Nelda Nortley was seriously ill in the hospital.

I spoke with direct care worker Cameron Greer by phone on October 6, 2021. He said that he and Nelda Nortley worked the midnight shift at Pinehaven Red on September 14, 2021. It was early morning, around 8:00 a.m., and they were preparing to give residents their medicine. Resident A came out of his bedroom and stated that he had fallen and that his arm hurt. Resident A had urinated on himself, so Mr. Greer assisted him into the shower. Mr. Greer stated that he observed a red mark on the back of Resident A's shoulder which he assumed was from the fall. Mr. Greer stated that Resident A has partial paralysis in his right arm and has limited motion in that arm. Mr. Greer stated that throughout the morning, Resident A could not move his arm at all and stated that it hurt. Mr. Greer stated that he wrote an incident report and called administrator Kris Rambo. Ms. Rambo stated that the CMH nurse was coming to the home the next day and could assess Resident A at that time. Mr. Greer stated that he told the staff coming in for their shift what had happened and to keep an eye on Resident A. He said that he was present when CMH nurse Ms. Lindsey Gaertney arrived at the home the next day. She looked him over and stated that he should be seen by the emergency department immediately. Mr. Greer stated that he took Resident A to the emergency department at that time and he was found to have broken bones. I asked Mr. Greer about any other possibility of how the injuries occurred or if they possibly happened during several falls. Mr. Greer stated that Resident A was fine before he went to bed the night before and that he and Ms. Nortley performed bed checks on him every half hour throughout the night, and observed that he was in his bed, sleeping, and seemed fine at those times. Mr. Greer stated that he felt the injuries had occurred during one fall right before Resident A came out of his bedroom that morning.

I spoke with CMH nurse Ms. Lindsey Gaertney by phone on October 7, 2021. She said that she made a site visit at Pinehaven Red on September 15, 2021. She was told that Resident A had had fallen the morning of the day before and that Resident A was expressing that he was in pain. Ms. Gaertney stated that she told them that if Resident A is in pain, then that is a change in his condition, and he needs to go to the emergency department immediately. Ms. Gaertney stated that the staff should have taken Resident A in after they noticed a change in his ability to move his arm

and he told them he was in pain. They did take Resident A into the emergency department right after she told them he should go in.

On October 8, 2021, I spoke with administrator Ms. Kris Rambo. I told her that there was some discrepancy about how long it took them to take Resident A to the emergency department. The complainant stated that it took two days while Mr. Greer reported that it took one full day. Ms. Rambo sent me documentation of her communicating with staff that indicated that it was one full day before they took Resident A to the emergency department.

| **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:** | Resident A could not move his arm after the fall and expressed pain. The staff did report the adverse change the next day to a CMH nurse. She felt they should have taken Resident A in immediately after the fall. At the hospital, Resident A was found to have significant injuries resulting from the fall. It was confirmed through this investigation that needed medical care was not obtained for Resident A in a timely manner after an accident and sudden adverse change in his physical condition. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION: Resident A and Resident B are not eating and are losing weight as a result. The staff are not mixing Resident B's Thick-It properly.**

**INVESTIGATION:** I spoke with Ms. Rebecca Flint with North Country Community Mental Health (CMH) by phone on September 15, 2021. She reported that she is concerned that Resident A and Resident B are not eating and are losing weight as a result. Both residents are very thin. The licensee did not report the weight loss to CMH. The CMH nurse, Ms. Lindsey Gaertney, was contacted regarding the weight loss. Ms. Flint reported that she is also concerned that they are not mixing Resident B's Thick-It correctly which is mixed with his food and drink.

On September 20, 2021, I spoke with Ms. Rambo about Resident A and Resident B not eating and losing weight. She said that they both usually eat a lot. According to Ms. Rambo they are both "naturally skinny" and do not put on a lot of extra weight. I asked Ms. Rambo about the report of Resident B not having his Thick-It properly mixed. She said that all the staff have been trained to properly mix the Thick-It and know to mix it to peanut butter or oatmeal consistency. Ms. Rambo showed me a

partial portion on the kitchen counter which was remaining after Resident B had been fed. She showed me that it was thick like oatmeal and believed that everyone knew how to mix it that way. Ms. Rambo stated the CMH nurse didn't believe that it was thick enough when she came in on one occasion, but all the staff have been trained on how to properly mix it now.

I received a call from the licensee designee Jonathan Harland, by phone on September 22, 2021. He said that both Resident A and Resident B have historically had good appetites and eaten well at the home. There have been no issues with Resident A and Resident B as far as he knew.

I made a site inspection at the Pinehaven Red adult foster care home on September 28, 2021. I wore personal protection equipment to protect myself and others. I spoke with administrator Ms. Kris Rambo who was on-site at the time of my inspection. She provided me with Resident B's Resident Weight Record (BCAL-3485) which recorded Resident B's measured weights from January 2020 through September of 2021. His weight, as recorded, only varied about 10 pounds during that time-period. His lowest recent weight was recorded as being 105 pounds on June 17, 2021. On August 15, 2021, his weight was recorded as being 110 pounds and on September 23, 2021, it was recorded as being 115 pounds. The weight record was missing documented weights for September of 2020, May of 2021 and July of 2021.

I spoke with direct care worker Cameron Greer by phone on October 6, 2021. I asked him about the report of Resident A and Resident B not gaining weight. He stated that they both eat a lot but do not seem to gain weight and have always been "skinny". Mr. Greer stated the staff give them both extra portions and Resident A always eats his extra portions during mealtimes. He also eats cookies throughout the day. He has never known Resident A to skip meals or snacks. Resident B also completes his meals although his situation is different because his food and drink is mixed with Thick-It. He eats well. I asked Mr. Greer about the report that the Thick-It is not always mixed properly. He said that it has been "drilled into their heads" that the Thick-It must always be applesauce or pudding consistency. All new staff who feed the residents are taught how to do this and shown exactly how to do it. Mr. Greer denied that he had ever known it to be mixed improperly during any of his shifts.

I spoke with CMH nurse Ms. Lindsey Gaertney by phone on October 7, 2021. She said that Resident A and Resident B were eating every time she visited or worked at Pinehaven Red. She said that they both "eat and eat". The staff will continue to feed Resident A and Resident B even after they finish their meals. Ms. Gaertney stated that she has "absolutely no concerns" about the residents at the Pinehaven Red home not eating. She went on to say that she has spent several hours at Pinehaven Red in the last several months. She has even worked several shifts there herself. During those shifts, she helped prepare meals and feed the residents. She has seen that they all eat well. The home is supposed to report to CMH, per the

contract, every time a resident loses 5 pounds or more in a week. That may have been missed by both parties, at times, due to the ongoing Covid-19 crises. In regard to Resident B's Thick-It, there had been some issues in the past with it not being mixed thickly enough. She has worked with the staff and noted recently that it is being mixed properly. Ms. Gaertney stated that she had no concerns about Resident B's Thick-It at this time.

On October 8, 2021, administrator Ms. Kris Rambo texted me a portion of Resident A's discharge from the emergency department on September 15, 2021. She highlighted that during his physical exam, they had indicated that Resident A was "well-nourished and well-hydrated".

| **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:** | Staff reported that both Resident A and Resident B eat well on a daily basis but both are naturally skinny. The CMH nurse, who has had frequent and lengthy contact with both Resident A and Resident B, confirmed this. The CMH nurse stated that she has worked with staff regarding the consistency of Resident B's Thick-It and believed that the staff are now mixing it properly.<br><br>Information was not discovered through this investigation that would indicate that there was a sudden adverse change with either Resident A or Resident B's health to justify obtaining needed care. |
| **CONCLUSION:** | VIOLATION NOT ESTABLISHED |

**ADDITIONAL FINDING:**

Administrator Ms. Kris Rambo provided me with Resident B's Resident Weight Record (BCAL-3485) which recorded Resident B's measured weights from January 2020 to September of 2021. The weight record was missing documented weights for September of 2020, May of 2021 and July of 2021.

| APPLICABLE RULE | |
|---|---|
| **R 400.14310** | **Resident health care.** |
| | (3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years. |
| **ANALYSIS:** | It was confirmed through this investigation that Resident B's weight record was missing documented weights for September of 2020, May of 2021 and July of 2021. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

I conducted an exit conference with licensee designee Mr. Jonathan Harland by phone on October 8, 2021. I told him of the findings of my investigation and gave him the opportunity to ask questions.

## IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change in the license status.

10/11/2021

Adam Robarge Date
Licensing Consultant

Approved By:

10/11/2021

Jerry Hendrick Date
Area Manager