GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 4, 2021

Melissa Doss
CMHB Of CEI Counties
Suite 115
812 E Jolly Road
Lansing, MI 48910

RE: License #: AM230249434
Investigation #: 2021A1029022
Arch Road Home

Dear Ms. Doss:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On September 28, 2021, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the plan.

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,

Jennifer Browning

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM230249434
Investigation #:	2021A1029022
Complaint Receipt Date:	08/04/2021
Investigation Initiation Date:	08/04/2021
Report Due Date:	10/03/2021
Licensee Name:	CMHB Of CEI Counties
Licensee Address:	812 E Jolly Road, Suite 115, Lansing, MI 48910
Licensee Telephone #:	(517) 346-8200
Administrator:	Melissa Doss
Licensee Designee:	Melissa Doss
Name of Facility:	Arch Road Home
Facility Address:	1081 Arch Road, Eaton Rapids, MI 48827
Facility Telephone #:	(517) 663-2401
Original Issuance Date:	11/14/2002
License Status:	REGULAR
Effective Date:	05/01/2020
Expiration Date:	04/30/2022
Capacity:	12
Program Type:	MENTALLY ILL

ALLEGATION(S)

	Violation Established?
Resident A was found deceased on his bedroom floor and direct care staff members did not use the automated external defibrillator (AED).	No
Additional Findings	Yes

II. METHODOLOGY

08/04/2021	Special Investigation Intake 2021A1029022
08/04/2021	Contact - Document Sent - Email to Ashlee Bailey from CMH Recipient Rights.
08/04/2021	Contact - Telephone call made to Julie Elkins, AFC Licensing Consultant
08/04/2021	Special Investigation Initiated - Letter - Email back from Ashlee Bailey ORR
08/06/2021	Contact - Telephone call made to Arch Road Home and spoke to Justin Perez
08/11/2021	Contact - Face to Face with Paul Ruggerio, Resident B at Arch Road Home
08/12/2021	Contact - Document Sent - Email to HR CEI CMH requesting training records and phone numbers.
08/12/2021	Contact - Telephone call made to direct care staff member, Angela Bell
08/12/2021	Contact - Document Sent - FOIA request for law enforcement report and dispatch records
08/13/2021	Contact - Document Received - Email from Sharon Blizzard with training dates and phone numbers
09/01/2021	Contact - Telephone call made to direct care staff member, Mai Vang
09/01/2021	Contact - Telephone call made to direct care staff member, Emily Lowe

09/01/2021	Contact - Telephone call made to Mason Outreach Clinic - left voicemail for Kelly Hicks
09/02/2021	Contact - Document Sent Email to Ashlee Bailey CMH
09/02/2021	Contact - Telephone call made to Skinner Funeral Home - Liz Evans
09/08/2021	Contact - Document Received - Recording from 911 call and event reports received
09/08/2021	Contact - Document Sent - Received denial from Eaton Rapids PD for police report and requested records from Michigan State Police
09/13/2021	Contact - Document - Sent Email to Melissa Doss and Paul Ruggerio requesting contact check logs.
09/14/2021	Contact - Telephone call made to direct care staff member, Christina Johnson
09/20/2021	Contact - Telephone call made to direct care staff member, Mary Mers
09/20/2021	Contact - Telephone call to direct care staff member, Vanesha Hernandez.
09/20/2021	Exit Conference with licensee designee, Melissa Doss
09/27/2021	Contact – Email to Paul Ruggerio and Melissa Doss.
09/28/2021	Contact – Telephone call to direct care staff member, Angela Bell.
09/28/2021	Exit Conference with licensee designee, Melissa Doss for additional finding.

ALLEGATION:

Resident A was found deceased on his bedroom floor and direct care staff members did not use the automated external defibrillator (AED).

INVESTIGATION:

On August 4, 2021, an incident report was received alleging that Resident A was found deceased on his bedroom floor. Direct care staff member, Angela Bell found him, called

911, but the direct care staff members did not use the automated external defibrillator (AED). The *AFC Licensing Division Incident / Accident Report* signed by Angela Bell on August 1, 2021 had the following description of the incident.

> *"During contact check (Resident A) was found on the floor cold to the touch. Grabbed AED and called 911. 911 instructed staff to see if there was reason to attempt AED/CPR. He was cold. 911 stated to not do CPR / AED."*

On August 6, 2021, I completed a search online for Resident A's obituary. The obituary said he passed away on August 1, 2021 and the funeral arrangements were made by Skinner Funeral Home in Eaton Rapids, MI.

On August 6, 2021, I interviewed direct care staff member, Justin Perez. He stated that Angela Bell was working and was the direct care staff member that found Resident A deceased. Mr. Perez heard that Resident A passed away in his sleep. Mr. Perez said that he was not working that day but worked with Resident A five days per week, usually Monday-Friday. He said that Resident A was not very healthy but that no one expected him to pass away. He described Resident A as being overweight but did not have cancer or chronic health conditions. Resident A complained occasionally of a headache but did not seem to be feeling worse than normal. Mr. Perez stated during Resident A's most recent doctor appointment was attended at Mason Outreach Clinic. Mr. Perez stated he did notice that Resident A spent more time in his room lately and had to be prompted for medication. Sometimes if Resident A felt unsteady at the facility, Mr. Perez stated Resident A used a walker. Mr. Perez stated Resident A returned from the psychiatric hospital on July 1, 2021 and seemed to be more withdrawn. Mr. Perez stated normally throughout the day, direct care staff members check on the residents each hour. In the mornings, residents are able to sleep in if they would like but Resident A typically was up by 10AM to take his medications.

On August 11, 2021, I interviewed home manager, Paul Ruggerio, at Arch Road Home. He gave the names of the direct care staff members that were working the morning of August 1, 2021 as Angela Bell, Mai Vang, and Emily Lowe. Mr. Ruggerio explained that all the training records and staff files would be available through human resources. Mr. Ruggerio was not working the morning of August 1, 2021. He stated that according to direct care staff members he spoke with Resident A took his medication and went to bed like a regular night the night before his death. He stated direct care staff are supposed to do contact checks but if resident bedroom doors are closed, direct care staff are not supposed to go into resident bedrooms. In the morning, when Resident A did not get up to take his medication, Mr. Ruggerio stated direct care staff member, Angela Bell went into the room to check on him and found he was cold to the touch. Ms. Bell called 911 immediately and she was advised not to use the AED since he was cold to the touch. Resident A recently returned from the psychiatric hospital and he appeared to be doing better. Mr. Ruggerio stated he did not notice that Resident A spent more time in his room. Mr. Ruggerio stated Resident A talked to everyone in the home but appeared to have the closest relationship with Resident B. Mr. Ruggerio did not believe they would be doing an autopsy and he was told that Resident A passed

from natural causes. Eaton County was the police department that responded to the 911 call.

Mr. Ruggerio stated the following items were found in Resident A's bedroom by law enforcement: one cup with two unknown medications, sleep aids, an empty ½ pint of Schnapps, 24 ounce empty can of Bud Light, and 1/5 of Jack Daniels which was mostly full. Arch Road Home does have a policy against bringing alcohol into the home but Mr. Ruggerio stated he could not enforce it since the facility no longer have house rules. Mr. Ruggerio explained the direct care staff members at Arch Road Home do not have any refresher trainings for AED machine or CPR once they are sent through the training. Once they complete the CPR / AED training, the direct care staff members are required to know what to do in case of an emergency. Mr. Ruggerio confirmed that since this was during the night and they do not go into the rooms for the checks, there was a delay in finding Resident A.

I was able to observe Resident A's former resident bedroom. Mr. Ruggerio pointed out where Resident A was found the morning of August 1, 2021 along with the AED device that is kept in the staff office closet. I examined the AED device and noted the picture on the back of the AED that explains what to do in case of an emergency. The pills that were found in the resident bedroom were in a cup in the dresser drawer. The separate sleeping aid OTC medication was likely purchased by Resident A at the dollar store. He has never seen an issue before with Resident A not taking his medications as prescribed. Mr. Ruggerio felt like Resident A was in good spirits. Before he passed, he talked to Mr. Ruggerio about an appointment he had for his back and told him that he actually loved living at Arch Road Home.

I was able to review Resident A's treatment plan through Community Mental Health-Clinton, Eaton, Ingham completed by John Berres, LMSW on February 11, 2021. There were goals in his treatment plan about Resident A wanting to improve his mental and physical health. Under *desired outcomes (hopes and dreams)* is the following statement:

> *"Client has expressed wanting to improve his physical and mental health. Client wants answers to why he feels like this way and wants to know if it is his mental illness, medications, a chemical imbalance or if it is more related to the aging issue. Client said he is not suicidal when asked. He puts it I have no plans for a gun, pills, knife, or a rope, however, "I can't go on living this way, so if that makes me suicidal, you tell me."*

Throughout the treatment plan, there are several goals listed. Most of the goals relate to improving physical health, finding other housing options, and possible work opportunities. Under crisis plan was the following statement:

> *"Consumer was informed that he can develop a crisis plan in case he relapses. Client will occasionally call EMT when feeling overwhelmed with his symptoms. Client appropriately goes to house staff when in distress or crisis."*

I interviewed Resident B who resided with Resident A for two years at Arch Road Home. He stated he was sad that his friend passed away. Resident A told him that he bought ten bottles and kept medication in his room that made him tired and that he was also drinking some Schnapps. Resident B believes that when direct care staff members passed medications, Resident A took some of his pills that made him tired and held on to them. Resident B stated a couple days before he passed, Resident A asked Resident B if he would “go get a gun and just shoot him.” Resident B told him to stop talking about such nonsense. He did not tell staff about it because he did not think that Resident A was being serious.

On August 12, 2021, I sent an email to human resources for CEI-CMH, Jana Baylis requesting the training records for CPR / AED for the staff members at Arch Road Home that were working the day of Resident A’s death and the schedule.

On August 12, 2021, I contacted direct care staff member, Angela Bell. Ms. Bell stated the medication time is between 8-10 a.m. each day. If the resident is not out right at 8 a.m. they are allowed to sleep in later. Around 9:35-9:40 am, Ms. Bell went down the hall to remind Resident A to take his medication. She was looking for him in his bed and he was not there but was instead lying in front of the bedroom door. Ms. Bell said his name twice and she went to touch him and she could tell that he was cold. Ms. Bell stated she ran to the kitchen to the other direct care staff members that were working and told them she thought that Resident A had passed. She told one of the direct care staff members to grab the AED and grab the phone to call 911. Ms. Bell stated she called 911 within three minutes and gave the address. The operator asked if she could do CPR on him but she advised the operator that she felt he was cold already. She could tell that he was deceased and the operator told her to not try to resuscitate.

Ms. Bell stated Resident A was found face down on the floor and his arms were underneath him with his legs were straight out. His room was not dirty but cluttered full of items. She did not look in the room or go back in after law enforcement responded to the scene.

Ms. Bell said she heard law enforcement found six pills, lidocaine patches 5%, an empty beer bottle, and a 1/5 of Jack Daniels. The lidocaine patches are prescribed to him. They give the patches to him and then he puts them under his pants. He was stashing them in his room instead of putting them on. There were six of them in his room. They were in his room in the package, unused. She has never noticed Resident A not taking his prescribed medication correctly. Eaton Rapids Fire Department and EMS responded to the call. Ms. Bell stated she has completed the CPR / AED training several times since her employment started. She knows her training is due for renewal soon and she is scheduled to complete another CPR / AED training on August 19, 2021.

Ms. Bell was able to explain the process of using the AED device in case of an emergency and where to put the pads on the individual. She was aware that the AED device told the user what to do and when the individual needed to be shocked.

Ms. Bell stated she worked with Resident A for four days each week and that Resident A had recently returned from the psychiatric hospital. She stated that he did not complain that he had any pain or psychiatric issues lately. In the past, sometimes he would take a Tylenol in the morning for pain or would say his back was bothering him.

Ms. Bell believes that Resident A's death was determined as a natural cause. She does not believe that he died by suicide. She said that Resident A and B were very close but she did not know that he said anything about having a gun. When Resident A has not felt well in the past, he has always reached out to them to call 911 or get assistance. He has told the direct care staff members in the past that he needs to go to the hospital.

On September 1, 2021, I was able to interview direct care staff member, Mai Vang. Her shift started at 9 a.m. on August 1, 2021 and she decided to find something to cook for lunch. While she was in the kitchen, Ms. Bell came and told her and Emily Lowe that she needed their assistance and went to check on Resident A. Ms. Vang stated she went to Resident A's bedroom door and saw him on the floor. Ms. Vang stated she called his name to see if there was a response and there was none. Ms. Vang stated she could tell Resident A was not breathing and noticed his toes were blue. Ms. Vang stated Ms. Bell went to get the AED and Ms. Bell called 911 dispatch. Ms. Vang stated that initially the dispatcher wanted Ms. Bell to use the AED but Ms. Bell told the dispatcher that he was "long gone" already so Ms. Bell was directed by the 911 dispatcher to not use the AED and they were informed EMTs were on their way. Ms. Vang stated EMTs, police, and medical examiner came to the home to assess and examine Resident A and a potential cause of death. Ms. Vang stated the direct care staff members were told he passed from natural causes. Before that day, Ms. Vang had not worked with Resident A for about a month. She said that he seemed distant after he came back from the hospital but she was unaware of any comments regarding him ending his life.

Ms. Vang stated she has worked for the agency for three years and has completed CPR /AED training. Ms. Vang was able to talk through the process of using the AED device and where to put the pads and that it follows directions.

Ms. Vang explained that the direct care staff members check on the residents one time per hour. Ms. Vang stated this happens during the third shift as well but typically she will knock and residents will verbally respond to her. If they are responding to her, she will not open it up. If she does not see a resident or they do not answer, she will peak in the door to see them. They do hourly checks and document their initials on the contact check log. Ms. Vang did not know if anyone checked on him during the 7 a.m. or 8 a.m. hours on August 1, 2021.

On September 1, 2021, I interviewed direct care staff member, Emily Lowe who worked on August 1, 2021, from 7 a.m.-3 p.m. She stated she was assigned to work with direct care staff member, Ms. Bell, and Ms. Vang. She was working with Resident A on the morning he passed. She was working on breakfast when Ms. Bell went to check on Resident A and remind him to take his medication.

Ms. Lowe stated Ms. Bell called for help from Ms. Lowe and Ms. Vang. Ms. Lowe stated she could see his body was blue and it was obvious to them that he was already deceased. Ms. Lowe stated the police arrived shortly after she heard Ms. Bell talking to dispatch and initially dispatch wanted them to use the AED or perform CPR however Ms. Bell told 911 dispatch that he was blue. Ms. Lowe stated they were told not to do it because he was already blue. Ms. Lowe did not touch him so she does not know if she was cold or not.

Ms. Lowe described that Resident A's body was approximately three feet from his door next to a sofa chair on the floor in his resident bedroom. Ms. Lowe did not search his room and said the police did this but she did not know if they found anything of concern.

Ms. Lowe stated she is a relief worker so she does not normally work at Arch Road Home often. Ms. Lowe stated she was familiar with Resident A and worked with him when he returned from the hospital and noted Resident A seemed confused about who she was which was strange for him because he was always familiar with her. As far as she knows Resident A was taking his medications regularly. Ms. Lowe heard that he passed due to natural causes and there was no plan for an autopsy.

Ms. Lowe stated she received training regarding the CPR / AED in September 2020. Ms. Lowe stated direct care staff members are required to do room checks each hour to determine the location of residents. She could not verify if there was a requirement to go into the rooms or open the door during the night because she does not work third shift. Ms. Lowe reported that typically residents are prompted for medications between 8-9 a.m. Ms. Lowe reported the facility also has a contact check log that includes the checks during the night. Ms. Lowe stated if a resident was sleeping during a contact check, she would not go into the room if it was early in the morning. She stated she would also not wake someone up while they were sleeping unless it was time for their medications. According to the contact check log sent by Mr. Ruggerio, Ms. Lowe completed the check for the 8 a.m. and 9 a.m. but did not enter the room.

On September 2, 2021, I emailed Ashlee Bailey from Community Mental Health (CMH) Recipient Rights and she confirmed there is nothing in Resident A's treatment plan that would require the home direct care staff members to do room checks each hour. She could not confirm there was a CMH policy that prohibited direct care staff from going in the resident rooms, however, with the level of independence that Resident A had, it is possible they were not going in as a way to respect his privacy.

On September 2, 2021, I contacted Skinner Funeral Home in Eaton Rapids and spoke with Liz Evans to inquire about the cause of Resident A's death. Ms. Evans sent a copy of Resident A's death certificate. The following health conditions were listed that directly caused the death for Resident A: diabetes mellitus, hypertension, hypothyroidism, smoker / chronic obstructive / pulmonary disease. Schizophrenia was listed as a significant condition contributing to his death. The manner of death was listed as natural

and an autopsy was not performed. He was pronounced dead at 10:08 a.m. on August 1, 2021, by Louis G. Valle, MD.

On September 8, 2021, the recording from the 911 dispatch call was received. Ms. Bell made the call to 911 dispatch stating that she was doing her contact check and medication reminder and found Resident A in his bedroom. The dispatch asked for basic information and then the operator told them that they needed to do CPR and to get the AED. There was commotion while they were getting the AED. The dispatch officer said, “do you have the AED near the patient?” and Ms. Bell stated, “He is gone, gone and that he had changed colors.” Ms. Bell then yelled to the other staff “did you grab the AED – is he breathing?” Ms. Bell stated on the phone that she was nervous and that she had never dealt with that situation before. The dispatch officer said they needed to CPR and then confirmed with the dispatch officer that he was not hard but cold to the touch. The dispatch officer asked her three different times if she did not want to do CPR and Ms. Bell stated again that he was gone. She confirmed with dispatch that he was beyond assistance. She was told to leave everything as they found it.

A denial was received from the FOIA request to Eaton Rapids Police Department with instructions to contact Michigan State Police. A request was sent on September 8, 2021, to Michigan State Police requesting the police report. An email was received on September 16, 2021, from Michigan State Police records department informing they were extending the time for responding to the request by ten business days and a written notice would be sent on or before September 30, 2021.

The event reports were received from EMS, Eaton Rapids Fire Department, and Michigan State Police on September 8, 2021. The event report from Michigan State Police and the Eaton Rapids Fire Department described the nature of the incident as a cardiac or respiratory arrest. The call was received at 9:54 a.m. from dispatch and law enforcement arrived at Arch Road at 11:27 a.m. In the event notes for the dispatch call, there is documentation that the AED was by the patient and he was cold to touch, caller stating he was beyond help. There were three additional statements: It appears the patient is obviously dead, the patient is cold and stiff in a warm environment, and the patient is unquestionably dead. The Eaton County 911 EMS event report confirmed that Ms. Bell contacted dispatch at 9:53 am and EMS arrived at the facility at 10:04 am.

On September 13, 2021, I emailed licensee designee, Melissa Doss and Paul Ruggerio for the contact check logs from July 31 and August 1, 2021 and they were provided. The contact log for July 31, 2021, included documentation Resident A in room 7 had hourly contact checks from 7 a.m. on July 31, 2021 to 9 a.m. on August 1, 2021. Each hour there is documentation that Resident A was either in his bedroom or the main area of the home with the exception of an activity out of the house at 1 p.m. on July 31, 2021. I also received documentation of CPR / First Aid / AED training for direct care staff that were working when Resident A was found deceased.

- Angela Bell – Last CPR class was taken on July 17, 2021. I confirmed on September 20, 2021, that she also completed the class again on August 19, 2021.
- Mai Vang – Last CPR class was taken on October 9, 2019
- Emily Lowe – Last CPR class was taken on November 5, 2020
- Mary Merz – Last CPR class was taken May 3, 2021
- Christina Robinson – Last CPR class was taken April 27, 2021
- Vanesha Hernandez – Last CPR class was taken May 6, 2021

On September 14, 2021, I interviewed direct care staff member, Christina Johnson who worked second shift 3:15 -11:30 (July 31, 2021) the day before Resident A was found deceased. Ms. Johnson stated she regularly works second shift with a part time schedule at Arch Road Home and was familiar with Resident A. She said that Resident A came out of his bedroom between 10-10:30 p.m. on July 31, 2021, to get a snack and then returned to his bedroom and nothing appeared out of the ordinary at that time. She described him as having a normal day. In the past, Ms. Johnson stated when Resident A felt like something was wrong, he told the direct care staff members. Ms. Johnson stated Resident A spent a lot of time in his room. She said the contact checks have changed because now they are not supposed to knock on the doors or open the doors. At the time of his passing, she was still opening the doors to verify that he was okay. Ms. Johnson stated she did not check to assure residents were breathing rather would only assure residents were physically present in their assigned bedroom. Ms. Johnson stated during the evening of July 31, 2021, she knocked on the door to Resident A's room and he answered at 11:00 p.m.

Ms. Robinson stated she was surprised to learn Resident A had alcohol and over-the-counter and prescription medication in his room because residents are not allowed to have these items in their rooms. However, Ms. Johnson stated the facility direct care staff members and/or administration do not do resident room searches to respect their privacy. She has given medication to him in the past and he has always taken it correctly.

On September 20, 2021, I contacted direct care staff member, Mary Mers who worked third shift the night before Resident A was found deceased. She worked third shift for a month but is now on day shift. She came in at 11 p.m.-7 a.m. Ms. Mers stated Resident A did not come out of his room at all during that shift. She said direct care staff members perform resident bedroom checks and peek in his room to see if the resident is there. When the checks were done during this shift, Resident A was in his room. They would tap on the door a bit to see if there was a response. She observed him in his bed at 6 a.m. Resident A never came out of his room complaining of being ill or having any concerns. Ms. Mers stated was not aware that Resident A had any alcohol or pills in his room. She heard that it was a possibility that he stored his medications but she did not see anything in his room however, she also was not looking for items in his room. Ms. Mers said that he seemed like he had a hard time remembering people when he came back to Arch Road Home after being in the hospital.

On September 20, 2021, I contacted direct care staff member, Vanesha Hernandez who worked with Ms. Mers the night of July 31, 2021. She said that she normally works first shift but was working third shift for that evening. She also started at 11:00 p.m. and Resident A was already sleeping and confirmed that he did not come out of his room during the night. Ms. Hernandez stated she did not hear any commotion in Resident A's room that would have caused concerns. Her coworker, Ms. Mers completed resident contact checks that night. Ms. Hernandez stated she was covering a shift at Arch Road so she did not have regular contact with Resident A. Ms. Hernandez has never noticed medication in his room in the past.

On September 20, 2021, I completed the exit conference with licensee designee, Melissa Doss. She stated that she did a refresher training on the AED at Arch Road to help refresh the direct care staff members on what was done.

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 was found deceased by direct care staff member, Angela Bell at Arch Road home the morning of August 1, 2021. Ms. Bell and her coworkers, Ms. Yang and Ms. Lowe, contacted 911 dispatch. Ms. Bell informed dispatch that Resident A's temperature was cold and he was deceased which led to the dispatch confirming this information and instructing Ms. Bell to not use the AED device since direct care staff member confirmed that he was beyond that level of assistance. According to Resident A's death certificate, the manner of death was natural and he had the following conditions that contributed to his death: Diabetes mellitus, hypertension, hypothyroidism, smoker / chronic obstructive / pulmonary disease, and schizophrenia. There is no indication that the direct care staff members working on July 31, 2021 or August 1, 2021 could have provided additional supervision, protection, and personal care in order to prevent the death of Resident A. After finding Resident A deceased in his room, they responded appropriately by contacting dispatch and seeking medical assistance.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On August 11, 2021, I reviewed Resident A's resident record. There is documentation from the Birch Health Center from February 24, 2021 from a preventative medicine visit that Resident A discussed chronic lower back pain which was worse with lying down and getting up from bed.

On August 12, 2021, I contacted direct care staff member, Angela Bell. Ms. Bell said she understood law enforcement found six pills, lidocaine patches 5%, an empty beer bottle, and a 1/5 of Jack Daniels in Resident A's resident bedroom. Ms. Bell stated Resident A's lidocaine patches were prescribed to him. Ms. Bell stated direct care staff members gave the patches to him which he then put on them under his pants on his own. Ms. Bell stated Resident A apparently was stashing them in his room instead of putting them on. Ms. Bell stated six lidocaine patches were found in his room. Ms. Bell stated the patches were in his room in the package, unused. Ms. Bell stated she never noticed Resident A not taking his prescribed medication correctly.

On September 28, 2021, I interviewed direct care staff member, Angela Bell again. She stated that the procedure for the lidocaine patches was to cut the patch open and then hand it to Resident A. Ms. Bell stated that she primarily works during the day shift but she believes that is what the other direct care staff members do as well since that is how they were trained. Ms. Bell stated Resident A would then go into his bedroom or the bathroom to apply the lidocaine patch on his own without direct care staff member assistance. Ms. Bell stated Resident A did this on his own because he applied it to his butt and lower back area. The direct care staff members did not watch him put the lidocaine patch on or take the old patch from him. The lidocaine patch was prescribed to him for pain and they were shipped by a medication delivery company. Ms. Bell stated Resident A was prescribed one patch each morning. Ms. Bell stated to her knowledge, there was no written documentation from his physician stating that he could apply the patch to himself without assistance or supervision.

APPLICABLE RULE	
R. 400.14312	**Resident Medications**
	(3) Unless a resident's physician specifically states otherwise in writing, the giving, taking, or applying of prescription medications shall be supervised by the licensee, administrator, or direct care staff.
ANALYSIS:	According to Ms. Bell, Resident A was prescribed lidocaine 5% patches and he was able to apply these himself. There is no indication the direct care staff members were supervising him appropriately while he applied the lidocaine patches or that a physician specifically stated in writing that he was able to apply these on his own. Law enforcement found six unopened patches in his resident bedroom after he passed away. Although Ms. Bell stated she never noticed that he was not taking this medication correctly, Resident A was not supervised while doing so since he was able to take the unused patches back to his resident bedroom.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

The police report from Michigan State Police has not been received at this time. If there are additional concerns regarding Resident A's death after reviewing that report, further investigation will be warranted.

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

Jennifer Browning

__ _____9/28/2021_____

Jennifer Browning
Licensing Consultant

Date

Approved By:

Dawn Timm

10/04/2021

_____

Dawn N. Timm
Area Manager

Date