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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 29, 2020

Jennifer Bhaskaran
Alternative Services Inc
Suite 10
32625 W Seven Mile Rd
Livonia, MI 48152

RE: License #: AS190010545
Investigation #: 2020A0466027
Bradford Home

Dear Ms. Bhaskaran:

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 (517) 284-9727.

Sincerely,

Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS190010545
Investigation #:	2020A0466027
Complaint Receipt Date:	06/02/2020
Investigation Initiation Date:	06/02/2020
Report Due Date:	08/01/2020
Licensee Name:	Alternative Services Inc
Licensee Address:	Suite 10 32625 W Seven Mile Rd Livonia, MI 48152
Licensee Telephone #:	(248) 471-4880
Administrator:	Jennifer Bhaskaran
Licensee Designee:	Jennifer Bhaskaran
Name of Facility:	Bradford Home
Facility Address:	7757 S Chandler Rd St Johns, MI 48879
Facility Telephone #:	(734) 453-8804
Original Issuance Date:	11/23/1981
License Status:	REGULAR
Effective Date:	06/25/2019
Expiration Date:	06/24/2021
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATIONS:

	Violation Established?
On 05/31/2020, Resident A was found on the concrete floor with facial injuries and visible blood.	Yes
Adult Foster Care (AFC) home staff drove Resident A to the hospital instead of calling for emergency medical service (EMS).	Yes

III. METHODOLOGY

06/02/2020	Special Investigation Intake 2020A0466027
06/02/2020	Special Investigation Initiated – Telephone call made to assigned APS worker Thomas Hilla.
06/02/2020	Contact - Document Received- Email from APS Hilla.
06/05/2020	Contact - Telephone call made- DCW Paige Conley interviewed.
06/05/2020	Contact - Telephone call made- message left for DCW Melinda Mead.
06/05/2020	Contact - Document Sent- documents requested from house manager Billie Leonard.
06/05/2020	Contact - Telephone call made to APS Hilla.
06/05/2020	Contact - Document Sent to ORR
06/15/2020	Contact - Telephone call received from APS Hilla
06/19/2020	Contact - Telephone call made- Second message left for DCW Melinda Mead.
06/23/2020	Contact - Telephone call made- Third message left for DCW Melinda Mead.
07/22/2020	Contact - Telephone call made- Fourth message left for DCW Melinda Mead.
07/27/2020	Contact - Telephone call made to Guardian A1, message left.

07/29/2020	Exit Conference with Jennifer Bhaskaran, message left.

ALLEGATION:

- **On 05/31/2020, Resident A was found on the concrete floor with facial injuries and visible blood. Concern preventative measures were not taken to prevent this fall.**
- **Adult Foster Care (AFC) home staff drove Resident A to the hospital instead of calling for emergency medical service (EMS).**

INVESTIGATION:

On 06/02/2020, Complainant reported Resident A has an intellectual disability and resides in an adult foster care (AFC) home. Complainant reported Resident A does not speak at all and does not hear well. Complainant reported Resident A has various physical health conditions including depression. Complainant reported on 05/31/2020, Resident A was in her bed when direct care staff members heard a loud noise. According to Complainant when direct care staff members entered Resident A's bedroom, she was lying on the concrete floor with facial injuries and visible blood. Complainant reported Resident A suffered facial fractures and a brain bleed. Complainant reported that the extent of the injuries does not match the facilities explanation of how Resident A's injuries occurred which was an assumed fall from bed. Complainant reported Resident A was transferred from one hospital to another due to the extent of the injuries and the need for further treatment. Complainant also reported Resident A had another fall in December 2019 and was again admitted to the hospital for multiple facial fractures and skull fractures due to a fall. Complainant reported Resident A had no other injuries at that time either. Complainant reported that it was explained by staff that Resident A falls frequently. Complainant reported that with this being the second major injury due to Resident A falling, it is unknown what is being done by to prevent Resident A from falling.

On 06/02/2020, I interviewed adult protective services worker (APS), Thomas Hilla who reported Resident A is currently hospitalized with a facial fracture. APS Hilla expressed concern that Resident A's injuries do not appear consistent with the explanation provided by the AFC which was that Resident A fell out of bed.

On 06/02/2020, I reviewed an email from Resident A's Case Manager Ericka Barber which stated:

> "My records show that [Resident A] has lived at Bradford AFC since 1981. [Resident A] has been showing an increase in behaviors such as screaming, more frequent falls, trying to sit in her closet, banging body/head. Billie and I have advocated for her to have tests completed and this year she has had blood work completed multiple times, a cat scan, Tylenol adding to her MARS to determine impact on scoliosis pain, received a gait belt, had her eyes and ears examined, procured psychiatry care in February and most recently obtained a hospital bed for her to sleep in. [Resident A] currently receives psychiatry care at

CMH and her last appt was completed May 20th and a follow up is scheduled for mid-June to determine efficacy of med change and if an appt is needed. [Resident A] currently receives Supports Coordination, a contract with Bradford to provide Community Living Supports and Personal Care staffing 24/7, and a Registered Dietitian on her team. With consent of father/guardian we will seek Occupational Therapy services through CMH as well. [Resident A] is also waiting to have a scan of her stomach to determine if scoliosis is pinching or impeding function of any organs. We will continue to explore any medical or behavioral options to best support her. If you have any ideas or further questions, please do not hesitate to reach out to me."

On 06/02/2020, I reviewed *AFC Licensing Division- Incident/Accident Report* completed by Team Coordinator Billie Leonard dated 06/01/2020, which documented that on 05/31/2020 at 1:30am in the "explain what happened/describe injury" section of the report "Staff heard a loud noise, upon checking on the consumers they found [Resident A] on the floor near her closet. Staff perform a body check and noticed bleeding by her right ear." Under the "Physician diagnosis of injury" section it documented "facial fracture, laceration of right ear and subdural hematoma." The "Action taken by staff" and "Corrective measures" sections of the report stated, "see attached." The attached document stated:

"Staff Melinda Mead called Billie Leonard and stated that they were taking her to Sparrow Clinton Memorial Emergency Room for medical evaluation. Dr. Sbalchiero was the attending physician and ordered labs, x-ray and CT scan. Results came back showing a facial fracture, laceration of right ear and subdural hematoma. She was transferred to Sparrow main campus for further evaluation. Resident A was admitted to Sparrow on 05/31/2020. [Resident A] has had some decline in her physical/mental status over the last year. Home has been working closely with her primary physician, psychiatrist and case management from CMH. Several different tests have been performed and they are all coming back negative for any disorder that would explain the reason for the decline. Home will continue to follow up with her physician and hospital recommendations including getting a hospital bed with rails due to fall risk through the night."

On 06/05/2020, APS Hilla and I interviewed direct care worker (DCW) Paige Conley who reported that she was on shift on 05/31/2020 with DCW Melinda Mead. DCW Conley reported that she was doing laundry and DCW Mead was in the kitchen cleaning when they both heard a loud noise that shook the entire house. DCW Conley reported that it sounded like someone ran into the wall. DCW Conley reported that she and DCW Mead went into the resident bedrooms area to check on the residents. DCW Conley reported that they went into Resident B's room first as she hits walls. DCW Conley reported that Resident B was in her bed asleep so she and DCW Mead continued to go into each room to check on the residents. DCW Conley reported that Resident A's room was the last room that they entered because her room is the furthest away at the end of the hallway. DCW Conley reported that she and DCW Mead found Resident A on the floor by the closet, which is near the door of the bedroom a far distance from Resident A's bed. DCW Conley reported

that the closet doors were shut. DCW Conley reported that Resident A could not have fallen out of bed and be found by the closet. DCW Conley reported that she saw blood on the floor and realized that the blood was coming from Resident A's right ear. DCW Conley reported that she was concerned about Resident A having a neck injury, so she reported staying with Resident A while DCW Mead called Team Coordinator Leonard. DCW Conley reported having concern about moving Resident A off of the floor due to the fall being unwitnessed and uncertain if Resident A had a neck injury. DCW Conley reported DCW Mead told her she would drive Resident A to the hospital. DCW Conley reported Resident A was not acting like herself because she was not screaming like she typically does, and Resident A was hitting her hand. DCW Conley reported DCW Mead got a wheelchair and she and DCW Mead assisted Resident A into the wheelchair to get her to the facility vehicle. DCW Conley reported she expressed concern to DCW Mead about moving Resident A and driving her to the hospital but DCW Conley reported that DCW Mead stated that this was what Team Coordinator Leonard directed them to do. DCW Conley reported Resident A is known to be fall risk and that Resident A was hospitalized in December 2019 for injuries related to a fall. DCW Conley reported Resident A also fell in January 2020 or February 2020 which did required medical attention. DCW Conley reported that she is aware of two other falls that Resident A had but reported that those were "safe falls" and did not require medical attention. DCW Conley reported that DCWs walk with Resident A when they can but that she does not require standby assistance from direct care staff members. DCW Conley reported she is not aware of any interventions to monitor/supervise Resident A to try to prevent her from falling or to assist her with walking. DCW Conley reported Resident A has been in her bedroom more and has been less social with the other residents since she began taking dementia prescribed medications. DCW Conley reported DCWs check on Resident A when she is in her room but there is not a required amount of have times necessary to check on Resident A nor is it required o document when Resident A is checked on by direct care staff members.

On 06/10/2020, I reviewed Resident A's *Sparrow Hospital Discharge Summary* which was dated 05/31/2020 and stated under the "history of present illness" section "Originally [Resident A] was evaluated at Sparrow Clinton, where she was found to have 8mm SDH on the right with multiple facial fractures. CT spine negative, CT chest/abdomen/pelvis not done. TXA bolus given, currently on TXA infusion. Neurosurgery (Abood) aware." Under the *Discharge Diagnosis*, section of the document, principal problem was "fall." Active problems "closed fracture of left zygomatic arch, closed fracture of medial and lateral wall of left orbit impression 1. No acute fracture seen. 2. Normal alignment. 3. There is no significant change when compared to the prior exam. Automatic exposure control was used as a close lowering technique." Resident A was simultaneously admitted to Sparrow Trauma services intensive care unit (ICU) on 05/31/2020 and was discharged on 06/08/2020. The *Discharge Summary* documented under "Procedures Performed: Endovascular Partial Embolization of AV fistula on 06/05/2020."

On 06/11/2020, I reviewed Resident A's order for gait belt that was prescribed on 01/21/2020. The order stated, "Gait belt to assist with ambulation." Resident A also has a physician's order for a wheelchair that was dated 11/08/2019 which stated, "Wheelchair for longer distances."

On 07/17/2020, APS Hilla reported Resident A was seen by her physician on 07/17/2020 and was referred for physical therapy (PT) to come into the facility and evaluate her needs. APS Hilla reported that there were no medication changes at this time. APS Hilla provided the *After-Visit Summary* which was reviewed.

On 07/27/2020, I reviewed Resident A's *Assessment Plan for AFC Residents* which was dated 01/30/2020 and documented that Resident A requires assistance for eating, toileting, bathing, grooming, dressing, personal hygiene and walking. Under the walking/mobility section it stated, "likes to scoot on floor, uses a wheelchair when needed out in the community." Under communication needs it stated, "non-verbal but uses body language, facial expressions and vocal sounds."

On 07/27/2020, Tamie Stevens, Operations Director reported that DCWs have worked with Resident A's primary care doctor and have taken her for several tests to rule out medical issues to try to figure out what is going on with her. Ms. Stevens reported the home staff have modified the environment by adding pool noodles to furniture. Ms. Stevens reported additional modifications that have been made, but those additional measures were implemented after Resident A's fall on 05/31/2020.

DCW Melinda Mead was on shift on 05/31/2020 when Resident A's injuries occurred and DCW Mead drove Resident A to the hospital. I attempted to contacted DCW Mead and left messages for her to return my calls on 06/05/2020, 06/19/2020, 06/23/2020 and 07/22/2020. As of the writing of this report, DCW Mead did not make herself available to be interviewed. DCW Mead works midnight shift.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	On 05/31/2020, Resident A was found on the concrete floor in by the closet in her bedroom bleeding with facial injuries, by DCW Conley and DCW Mead. According to the *Incident/Accident Report* and Sparrow Hospital reports Resident A suffered facial fracture, laceration of right ear and a subdural hematoma. Resident A was quickly transferred from Sparrow Clinton Hospital to the Lansing ICU Sparrow Trauma Services where an Endovascular Partial Embolization of AV fistula procedure completed on 06/05/2020. Additionally, Resident A was hospitalized in December 2019 for injuries related to a fall and DCW Conley reported that Resident A has fallen several times since, although medical attention was not always necessary. According to DCW Conley and APS Hilla, Resident A has been determined to be a fall risk. Resident A has been through medical tests and medication changes but that did not improve her gait or decrease her falls. Although the facility was working with the case manager and medical providers to identify an organic reason for Resident A's unsteady gait and continued falls, there were no established supervisory plans to maintain Resident A's safety despite the continued falls or any preventative measures taken to mitigate future falls, therefore a violation has been established. Further, DCW Mead drove Resident A to the hospital in the facility vehicle rather than calling 911 for emergency transportation despite seeing clear evidence of facial and possible neck and head injury. Again, Resident A's protection and safety needs were not attended to when DCW Mead made this decision to transport rather than call emergency services.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

07/29/2020

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Julie Elkins Date
Licensing Consultant

Approved By:

07/29/2020

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Dawn N. Timm Date
Area Manager