GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 21, 2021

Deborah Daly
Summertree Residential Centers, Inc.
210 N Lake Street
Boyne City, MI 49712

RE: License #: AS150010499
Investigation #: 2022A0009010
Springridge Home

Dear Ms. Daly:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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 the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- A specific time frame 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 #:	AS150010499
Investigation #:	2022A0009010
Complaint Receipt Date:	12/01/2021
Investigation Initiation Date:	12/01/2021
Report Due Date:	12/31/2021
Licensee Name:	Summertree Residential Centers, Inc.
Licensee Address:	210 N Lake Street Boyne City, MI 49712
Licensee Telephone #:	(231) 582-2225
Administrator:	Karl Kuzmik
Licensee Designee:	Deborah Daly, Designee
Name of Facility:	Springridge Home
Facility Address:	520 State Street Boyne City, MI 49712
Facility Telephone #:	(231) 582-6921
Original Issuance Date:	05/04/1992
License Status:	REGULAR
Effective Date:	02/28/2021
Expiration Date:	02/27/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A has been discouraged from leaving the facility. She spends 23 of 24 hours of the day in her bedroom.	No
Resident A was not given enough of her medication when she left the facility during the Thanksgiving weekend.	No
A record of contacts with Resident A's physician have not been properly maintained.	Yes

III. METHODOLOGY

12/01/2021	Special Investigation Intake 2022A0009010
12/01/2021	APS Referral
12/01/2021	Special Investigation Initiated – Telephone call received from adult protective services worker Ms. Brooke Bachelor
12/03/2021	Inspection Completed On-site Interview with Resident A and direct care worker Ms. Deborah Weisler
12/08/2021	Contact – Telephone call made to Resident A
12/08/2021	Contact – Telephone call made to Community Mental Health (CMH) recipient rights officer Ms. Brandy Marvin
12/17/2021	Contact – Telephone call received from home manager Ms. Kersten Polena
12/17/2021	Contact – Document received from home manager Ms. Kersten Polena
12/20/2021	Contact – Telephone call made to administrator Mr. Karl Kuzmik
12/20/2021	Exit conference with licensee Ms. Deborah Daly

ALLEGATION: Resident A has been discouraged from leaving the facility. She spends 23 of 24 hours of the day in her bedroom.

INVESTIGATION: I spoke with adult protective services worker Brooke Bachelor by phone on December 1, 2021. She said that Resident A lives at Springridge Home which is an adult foster care (AFC) facility. Resident A is wheelchair-bound and currently has a level three bedsore on her buttock. Resident A has complained about not being able to meet up with people she meets on-line. The bedsore has been an issue. Resident A did see a physician about it in May of 2021 who did not want her to travel. There is also a note from a physician dated November 19, 2021, that advises that Resident A not travel. Resident A's guardian has reportedly given Resident A "access to the community" and she does not have any restrictions on leaving the facility when she chooses. Resident A is allegedly kept in her bedroom for 23 out of 24 hours per day.

I conducted an unannounced site inspection at the Springridge home on December 3, 2021. I wore personal protection equipment to protect myself and others. Resident A was present at the time of the visit and I spoke with her. After some preliminary discussion, I asked her how things were going. Resident A stated that she didn't like living there anymore. She said that she did not feel she had anything in common with the other residents. She explained that they are much older than her and most of them do not communicate verbally. Resident A said that she had recently requested a new Community Mental Health (CMH) caseworker. She did that because of her wish to live independently and her feeling that her old caseworker did not support her in that. Her former caseworker felt that she made poor decisions. Resident A acknowledged that she had made poor decisions in the past but that she was making better decisions now. I asked her about Thanksgiving weekend. She said that she wished to spend Thanksgiving weekend with her boyfriend who she met on-line. Her old caseworker felt that she should have a "chaperone" when meeting the man for the first time but she did not want that. She did however spend the Thanksgiving holiday and weekend after with him downstate. He broke up with her at the end of the weekend. I asked her if she had been told she couldn't leave the facility before Thanksgiving weekend. Resident A said that she hadn't really asked to leave before Thanksgiving weekend. She said that she had told personnel at the facility that she was leaving with the man the day before Thanksgiving. They had initially told her that she shouldn't leave because of the pressure sore on her bottom. Resident A explained that it had been a level 3 pressure sore but was then better. It broke open again when she was with her former boyfriend that weekend and it is worse now. Resident A said that she knew the risks and still wanted to go. She said that she had been to the doctor two or three times regarding the sore. The last time was in October of 2021. She said that she knew that she was supposed to be off her bottom again until it healed.

I then spoke with direct care worker Deborah Weisler. She said that as far as she knows, Resident A is able to leave the facility any time she wants. Ms. Weisler stated that when they are short-staffed, they are not always able to transport her. They always need two staff on duty. They sometimes do not have that extra staff who is able to take her wherever she wants to go. They have never told her that she couldn't leave but have spoken with her about ways to ensure that she will be safe.

She explained that Resident A goes on dating sites to meet men and then wants to leave with them without knowing anything about them. The staff have only asked her to involve the guardian so the guardian knows about the situation and can help Resident A make a good decision. Ms. Weisler provided me with Resident A's Assessment Plan for AFC Residents (BCAL-3265). I noted that it was checked "Yes" in regard to whether Resident A "Moves Independently in Community".

I spoke with Resident A by phone on December 8, 2021. I asked her how things were going for her. She said that things were okay but that she is still waiting to live independently in her own place. Resident A said that the Springridge Home is just not her "forever home". I asked her about her staying in her bedroom 23 out of 24 hours per day. Resident A said that she believed that might be true on some days. She stated that she is trying very hard to stay off her pressure sore right now and that it is easiest to do that in her bedroom. She knows that she can go out in the living area any time she wishes to. Resident A explained that she doesn't communicate with the other residents. Some of them are loud and make "unnecessary noises". She said that she knows that it is not their fault but that she doesn't always like being around them.

I spoke with CMH recipient rights officer Ms. Brandy Marvin by phone on December 8, 2021. She is looking into whether Resident A was restricted from being able to leave the AFC home. Ms. Marvin explained that Resident A's CMH Care Plan indicates that Resident A should be moving towards independence and there should be no restrictions on Resident A's social life. She understood if staff at the facility were protective of Resident A but staff should not restrict her. It may be that staff at the facility were just taking direction from Resident A's caseworker. This is the matter that Ms. Marvin is currently investigating.

I spoke with home manager Kersten Polena by phone on December 17, 2021. She said Resident A initially felt restricted from her social activities because of the Covid-19 pandemic. She was not allowed to have visitors for a while at the beginning of the pandemic. Resident A did have a job after that but because of the pressure sore that developed on her bottom, was unable to continue. I asked Ms. Polena about any restrictions that Resident A had regarding her social activities. Ms. Polena stated that Resident A's former CMH caseworker had told them that if Resident A was going out with a man she met on-line, they should get a copy of his identification, his telephone number and a photo of his license plate. The new caseworker told them that this is a violation of her privacy and that they should let her go with whomever she likes if her guardian okays it. That was the latest guidance they received from CMH. Resident A has agreed to tell them who she is with and where she is at. That is her own decision to give them that information. Ms. Polena stated that she was currently at the hospital with Resident A. Resident A was with a new boyfriend in Houghton Lake. Resident A had a stress-induced seizure while she was with him.

I spoke with administrator Karl Kuzmik by phone on December 20, 2021. He denied that there were any restrictions for Resident A regarding her social activities. Mr. Kuzmik stated that they had been somewhat limited lately due to a staffing shortage. They need two staff at the home at all times and there is not usually a third staff on hand to transport Resident A. He said that last week and this week Resident A has been using the public transit system and that this has worked well for her. Resident A's former caseworker had believed that Resident A should not travel per the doctor's order but Resident A was never restricted. Resident A had been allowed to travel downstate to see her boyfriend during the Thanksgiving holiday. She now has a new boyfriend in Houghton Lake who she visited last week and who she will be spending time with during the holiday. Resident A's new CMH caseworker set this up with Resident A's guardian so the "bases are covered".

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: (b) The right to exercise his or her constitutional rights, including the right to vote, the right to practice religion of his or her choice, the right to freedom of movement, and the right of freedom of association. (2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.
ANALYSIS:	It was confirmed through this investigation that Resident A has had the right to freedom of movement. She recently traveled downstate to see her boyfriend. Resident A told me that she hadn't really asked to leave before that time. Resident A has also recently spent time with a new boyfriend in Houghton Lake and has plans to return to spend time with him during the holidays. It was confirmed through this investigation that the licensee did respect and safeguard the resident's rights.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A was not given enough of her medication when she left the facility during the Thanksgiving weekend.

INVESTIGATION: On December 1, 2021, adult protective services worker Brooke Bachelor reported that Resident A did leave for the Thanksgiving weekend to stay with a man she met on-line. She requested that she have enough medication to take with her through November 28, 2021 and the facility did not give her enough medication to last through November 28, 2021.

I spoke with Resident A about her medication on December 3, 2021. She reported that she went to her boyfriend's home on November 24, 2021 and stayed until November 28, 2021. I asked her if staff at the facility gave her enough medication to last her through November 28, 2021. Resident A replied that she had originally only planned on staying through November 27, 2021. That is what she told staff at the facility and that was why she was only given medication through November 27, 2021. Resident A went on to say that her guardian was the one to give her the ride downstate where her former boyfriend lives. Something came up for her guardian and she couldn't come to get her until November 28, 2021. Resident A acknowledged that she did miss her medication on the morning of November 28, 2021, but it was not the fault of the facility.

I spoke with administrator Mr. Karl Kuzmik by phone on December 20, 2021. He was not at the facility during the Thanksgiving holiday. He did know that the original plan was for Resident A to stay downstate through November 27, 2021. It was actually Resident A's guardian who had to change the return date while Resident A was already downstate. Resident A's guardian then brought Resident A back on November 28, 2021. Resident A did miss her morning dose that day. In the future, they will give Resident A an extra day's worth of medication in case of any eventuality.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(5) When a resident requires medication while out of the home, a licensee shall assure that the resident or, in the alternative, the person who assumes responsibility for the resident has all of the appropriate information, medication, and instructions.
ANALYSIS:	It was confirmed through this investigation that Resident A planned on returning to the facility on November 27, 2021. She was given enough medication to last through November 27, 2021. Resident A's guardian, who had agreed to transport her, had to change the plan and could not return her until November 28, 2021.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: A record of contacts with Resident A's physician have not been properly maintained.

INVESTIGATION: On December 1, 2021, adult protective services worker Ms. Brooke Bachelor reported that while on-site at the facility she noted that they did not keep a record of all of Resident A's physician contacts.

On December 3, 2021, I asked direct care worker Deborah Weisler if she could provide me with Resident A's recent record of physician contacts. Ms. Weisler provided me with Resident A's file and helped me find the medical section. I noted a health care appraisal dated May 28, 2019, an emergency room summary dated February 5, 2021 and a faxed note from a physician that had a fax notice date of November 19, 2021. The note dated November 19, 2021 read, "To whom it may concern. The patient is currently under my care. She has an open wound on her buttock. She is to remain off her bottom until the wound is healed. It is recommended that she not travel at this time. (Resident A's physician)." Ms. Weisler also provided me with Resident A's "Medical Appointment Profile". This appeared to be an agency face sheet for a resident's medical appointments. The face sheet listed "11/13/20" with the next entry being "10/5". There is no year given for the last entry but it is assumed that it occurred in 2021. There are no other medical appointments listed for 2021.

I spoke with home manager Kersten Polena by phone on December 17, 2021. She said that she believed that Resident A was initially seen by a physician in January of 2021 for her pressure sore. She was then seen in May of 2021. The doctor ordered that she stay off her bottom until the sore healed. I told her that it appeared as though Resident A's file did not contain a record of all her physician contacts. Ms. Polena said that it was her mistake that those did not all make it into Resident A's file. She said that she would contact Boyne Area Medical Center and see if they could gather those for her. Ms. Polena said that she would pick those up there as soon as she could. I told her that even the face sheet for Resident A's medical appointments did not seem to be complete. Ms. Polena stated that she had been on leave and would be catching up on that as well.

Ms. Polena sent me an email with attachment shortly following our discussion. She sent a note with Resident A's identifying information on top. There was no date on the note. It read, "To who it may concern. The patient is currently under my care. Please excuse him/her from work until further notice. (Resident A's physician)."

I spoke with administrator Karl Kuzmik by phone on December 20, 2021. He said that he had talked to the home manager and that she ackowledged that she had not had a chance to file all of Resident A's medical contacts. She told him that the paperwork had been sitting in a separate file. The staff who were on-hand when the adult protective services worker and I asked for the paperwork did not know that it was in a separate file. The home manager also admitted to him that she did not fill out the "Medical Appointment Profile" properly.

APPLICABLE RULE	
R 400.14316	**Resident records.**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: (d) Health care information, including all of the following: (i) Health care appraisals. (ii) Medication logs. (iii) Statements and instructions for supervising prescribed medication, including dietary supplements and individual special medical procedures. (iv) A record of physician contacts. (v) Instructions for emergency care and advanced medical directives.
ANALYSIS:	It was confirmed through this investigation that a record of all of Resident A's physician contacts were not available for review. Some records were present but not all. If those records were on-site, the staff who were present during my inspection as well as the adult protective services worker's visit were unaware of their location. The agency form Medical Appointment Profile for Resident A was also incomplete. Only one appointment was listed for Resident A in 2021. It is known that Resident A had several medical appointments during the calendar year 2021.
CONCLUSION:	**VIOLATION ESTABLISHED**

I conducted an exit conference with licensee designee Deborah Daly by phone on December 20, 2021. I told her of the findings of my investigation and gave her the opportunity to ask questions.

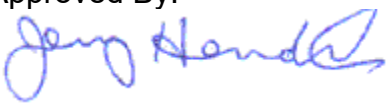
IV. RECOMMENDATION

I recommend no change in the license status.

Adam Robarge 12/21/2021

Adam Robarge Date
Licensing Consultant

Approved By:



12/21/2021

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Jerry Hendrick Date
Area Manager