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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 8, 2022

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

RE: License #: AS610016308
Investigation #: 2022A0357004
Brooks CLF

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 (616) 356-0100.

Sincerely,

Arlene B. Smith

Arlene B, Smith, MSW, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4213

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS610016308
Investigation #:	2022A0357004
Complaint Receipt Date:	11/24/2021
Investigation Initiation Date:	11/24/2021
Report Due Date:	01/23/2022
Licensee Name:	Samaritas
Licensee Address:	8131 East Jefferson Avenue Detroit, MI 48214-2691
Licensee Telephone #:	(231) 773-6593
Administrator:	Ann Meldrum
Licensee Designee:	Ann Meldrum
Name of Facility:	Brooks CLF
Facility Address:	599 S. Brooks Road Muskegon, MI 49442-2707
Facility Telephone #:	(231) 773-6593
Original Issuance Date:	01/08/1995
License Status:	REGULAR
Effective Date:	01/17/2022
Expiration Date:	01/16/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A fell and was crying repeating the word “hospital.” Two direct care staff could not lift Resident A off the floor. Once she was at the hospital she was diagnosed with several breaks in her leg, ankle and foot.	Yes

III. METHODOLOGY

11/24/2021	Special Investigation Intake 2022A0357004
11/24/2021	Special Investigation Initiated - Telephone Spoke with Darcey Home Supervisor about the situation.
11/24/2021	Contact - Document Received Received the Incident/Accident report and signed statements from staff.
11/24/2021	Contact - Document Received Darcy Torrey emailed me the AFC Incident Report and related documents pertaining to Resident A’s fall.
12/09/2021	APS Referral
12/09/2021	Contact - Telephone call received From Darcey, Home Manager.
12/17/2021	Contact - Document Received Received and reviewed Recipient Rights Report from Recipient Officer, Lawrence O. Spartaro, from HealthWest, Muskegon's Behavioral Wellness Connections (CMH).
01/05/2022	Contact - Telephone call made To Darcy Torrey, and we discussed the complaint.
01/26/2022	Contact – Telephone call made Interview with Direct Care Staff, Chanteigiah Collins.
01/27/2022	Inspection Completed On-site
01/27/2022	Contact - Face to Face With Licensee Designee, Ann Meldrum, Home Manager, Darcy Torrey and I conducted a face-to-face interview with Direct Care

	Staff, Kassie Davis. Resident A was back in the hospital so I could not interview her.
01/27/2022	Contact Document (s) received and reviewed Resident A's Health Care Appraisal, PCP and her Assessment Plan.
02/08/2022	Exit conference by telephone with the Licensee Designee, Ann Meldrum.

ALLEGATION: Resident A fell and was crying and repeating the word "hospital." Two direct care staff could not lift Resident A off the floor. Once she was at the hospital she was diagnosed with several breaks in her leg, ankle and foot.

INVESTIGATION: On 11/24/2021, I received a telephone call from the Home Supervisor, Darcy Torrey. She stated that she used her cellphone to provide the times of the telephone calls. She explained that she had received a telephone call from a guardian (Witness 1) of another resident in the home at 5:25 PM. She stated that Witness 1 was returning to the home with the resident and when she got into the Brooks CLF home, she saw Resident A sitting on the floor and staff were struggling to get her up. Ms. Torrey stated that Witness 1 expressed concern as it looked like they needed help. Ms. Torrey reported that she telephoned the Brooks CLF home at 5:26 PM and spoke with Direct Care Staff, Cheyenne Perysian who had answered the phone and she asked Ms. Perysian what was going on. Ms. Torrey reported she could hear Resident A crying in the background. Ms. Torrey stated that Ms. Perysian told her that Resident A had thrown herself onto the floor, and then stated further that (Direct Care Staff) Chanteighia Collins and herself had tried to get Resident A off the floor but were unable too. Ms. Torrey said she hung up and immediately telephoned Kassie Davis (PC-Program Coordinator) who lives 2 or 3 minutes away from the AFC home at 5:27 PM and explained the situation. She said Ms. Davis called her back at 5:31 PM and said she was at the Brooks CLF home, and they could not lift Resident A. Ms. Torrey stated that Ms. Davis asked for permission to have her boyfriend who was in the car help them lift Resident A from the floor. Ms. Torrey said she gave Ms. Davis permission to have the boyfriend come into the home and assist lifting Resident A from the floor. Ms. Torrey said that Ms. Davis called her back at 5:33 to inform her that her boyfriend was able to get Resident A lifted off the floor and into a chair. Ms. Torrey stated that Ms. Davis reported that Resident A was unable to stand and needed to go to the hospital. Mr. Torrey stated to me that Resident A does not have a history of throwing herself onto the floor and that this must have been some kind of accident. Ms. Torrey stated that she called Centralized Intake to make a complaint and she contacted director of Recipient Rights, Lawrence Spataro at HealthWest. Ms. Torrey reported that the two direct care staff, Ms. Colins and Ms. Perysian along with Ms. Davis and herself had written statements and she would send them to me.

On 11/24/2021, I received an email from Ms. Torrey with the attachments.

On 11/24/2021, I received and reviewed the AFC Licensing Division – Incident / Accident Report, which was signed by Cheyenne Perysian, on 11/21/21. The date of the incident was 11/21/21, at 5:20 PM. Ms. Perysian wrote *"(Resident A) fell in the dining room.* Action taken read: *"See attached pages."* Corrective measures taken read: *"Staff will be more aware of what is going on."* Ms. Torrey had signed the report on 11/22/21.

On 11/24/2021, I received and reviewed a signed hand printed statement by direct care staff, Chanteighia Collins, dated 11/21/21 on a form entitled *Incident Report Addendum.* It read as follows: *"While I was cooking dinner another roomate was pulling up the driveway getting ready to come in. (Resident A) begins to cry out of no where as I turned around I see (Resident A) out the door window as I was asking whats wrong. (Resident A) turns from the door and just fall to the ground. One and another employee tried multiple times to get her back in her chair. We weren't able to do so." {sic}*

On 11/24/2021, I received a signed hand printed statement from direct care staff, Cheyenne Perysian on the *Incident Report Addendum,* dated 11/21/2021. Her statement read as follows: "*I Cheyenne Perysian was sitting at the dining room table when (Resident B) and her mom pulled in the driveway. (Resident A) was sitting across from me. I got up and went to the living room to begin closing the curtains. I shut the first curtain and I heard (Resident A) start to cry. I went to close the second curtain and when I turned around I heard (Resident A) fall, she started crying louder. I came into the dining room and saw (Resident A) on the floor, sitting on her butt between the door and her chair. I asked her if anything hurt and put the chair in front of her and asked her if she could get up. My coworker and I tried to get her to sit in her chair and we couldn't. Then we just waited for the PC arrived."*

On 11/24/2021, I received and reviewed the signed *Incident Report Addendum,* by Kassie Davis PC. dated 11/22/21. The report read as follows: *"At 5:27pm, I got a call from Darcy (home manager) stating that (Resident B's) guardian called her and told her that (Resident A) was on the floor and nobody could get her up. I drove to brooks got here around 5:30. When I arrived at the house (Resident A) was screaming very loud, I could hear her from outside. She was sitting on the floor by her chair with her legs straight out. I attempted to get her up by myself, when that didn't work I looked around at the other two staff members. One was just standing there watching me and the other one was by the stove on her phone. I then went outside and asked my boyfriend to come in and help (he has been approved to come into the house.) We got her up and we sat her in the chair next to her. She was screaming go to the hospital. I called Darcy from the brooks land line at 5:33 pm and told her that me and my boyfriend got her up, I also told her that she wouldn't put any pressure on it and she was screaming to go to the hospital. She told me to call the on call nurse. I spoke with Nikki (Nichole Dulinski -Registered Nurse) I explained what happened and that she couldn't put no pressure on it and she was*

yelling to go to the hospital. She told me that she needed to be seen. I explained that there was no way to get her to urgent care. When I called the number she gave me it transferred me to dispatch. (Resident A) was still screaming at this point so I did ask her if I could give her a PRN to help her calm down. She told me yes so I passed a 0.5 mg tablet of Klonopin. Ambulance got here, the lady looked at her ankle and said it was very swollen and that she needed to go to the ER in case it was in fact broke. I called Darcy to tell her, I rode with her in the ambulance, I told Darcy that I would see how everything went and then call her with results. We got to the hospital and got right into the room. The doctor came in right away and looked at her ankle and leg. It was very swollen. He ordered x-ray of the foot, ankle and leg. She got very loud and started trying to hit me (she was very upset that she to take her sock off). I then asked for something for pain and something to calm down. Maybe like five minutes later the doctor came in and said she broke her Tibia and Fibula and would require surgery the next day. I called Darcy and told her everything and she said she was going to drive in to the hospital. They did an IV and gave her more pain meds and something to calm her down because they had to wrap her leg. After all that was done I left around 8:30." {sic}

On 11/24/2021, I received and reviewed the signed handprinted statement on the *Incident Report Addendum* by Darcey Torrey, dated 11/22/2021. The report read as follows: *"At 5:25 p the parent of (Resident B) called me and asked if the home called me. I said no why {?}. She stated that they looked like they needed help. I called the home at 5:26 p. I asked them what was wrong because I could hear (Resident A) in the background crying. I was told by Cheyenne that (Resident A) threw herself on the floor. I stated that she does not do that. I asked again what happened and she said that she did not know. I asked if they were able to get her up and she said no. I called Kassie at 5:27 p and I asked her to go see what was going on. She called me from the home at 5:33 p and said they got her up but she was not putting weight on her foot. I told her to call the on-call nurse. She called me back and said (Resident A) needed to go in. She called 911 and had her transported to the hospital where it was found that (Resident A's) right leg was broken in multiple places and requires surgery. *Kassie was unable to get (Resident A) up by herself, I approved her boyfriend Will to come in and help. He has previously been approved to come into the home."*

On 12/17/2021, I received and reviewed "Report of Investigative Findings," by Lawrence O. Spataro, Recipient Rights Officer. Mr. Spatarpo wrote in his report that Resident A remained in the hospital and "is not able to respond to abstract questions." His report indicated on 11/30/2021 he had interviewed; Darcy Torrey, Home Supervisor, Kassie Davis, On-call Staff; Cheyenne Perysian, Direct Care Staff; Chanteigiah Collins, Direct Care Staff; and Witness 1. His report contained a summary of his interview with Kassie Davis. His report stated that Ms. Davis told him that while they were getting Resident A into a chair Ms. Perysian and Ms. Collins put dinner on the table for the other residents. His report read: "When asked where the other staff were when she arrived. Kassie Davis said she could hear (Resident A) screaming from outside, and when she entered Brooks, Chanteigiah

Collins was by the stove on her phone and Cheyenne Perysian was by the cupboard. Kassie Davis said (Witness 1) was in the living room with her daughter. She said they put the food down on the table right after she arrived. Kassie said (Resident A) was on the floor between the dining room and table and a chair facing the closet by the front door. She said (Resident A) was screaming “Hospital!” “Hospital!” Kassie Davis said Chanteiriah Colins never got off her phone and even the Guardian (Witness 1) asked her to get off her phone. Kassie Davis and Chanteigiah Collins and Cheyenne Perysian told her they did not know what happened.”

Mr. Spataro’s report read: “(*Witness 1) said she heard (Resident A) screaming bloody murder as soon as she got there which was between 5:00 and 5:30 pm. She said she pulled in and got her daughter out and could see the window that Chanteigiah Collins was on the phone and Cheyenne Perysian was trying to get (Resident A) off the floor. (Witness 1) said she called Darcy Torrey before she even got in the home. (Witness 1) said Chanteigiah Collins was talking on the phone on a personal call. She said (Resident A’s) foot was at an odd angle, and she was grayish. (Witness 1) said Chanteigiah Collins was on off the phone the whole time and she was there texting. (Witness 1) said (Resident A) was on the floor by the front door. She said Kassie Davis and her boyfriend arrived shortly after she did and got (Resident A) into a chair and then the ambulance arrived. (Witness 1) said she had the impression the incident has just happened when she arrived. She said Cheyenne Perysian was trying to be helpful, but she was shaking so much she could not put food in her daughter’s feeding tube. (Witness 1) said Chanteigiah Collins was on her phone. She said at one prompt she asked Changeigiah Collins if she was on a business call. (Witness 1) said once (Resident A) was in the chair Chanteigiah Collins and Cheyenne Perysina put dinner on the table. She said she was there about an hour.”*

Mr. Spartaro’s report indicated he interviewed Cheyenne Perysian and she made additional comments that included that she heard Resident A make noise then heard her fall. She said after she found Resident A sitting on her butt and she tried to get her to stand by using a dining room chair. It was at this point that Resident A was just screaming and crying and Ms. Perysian stated, “*I thought she was having a behavior.”* She also reported to Mr. Spartaro that Witness 1 was on the phone with Darcy Torrey as she entered the home. His report read: *“When asked why she started closing curtains when she saw Witness1 pull up, Cheyenne Perysian said, “I just wanted to be doing something.” “She stated further that Witness 1 often criticizes her for sitting around.”*

Mr. Spartaro’s report indicated he interviewed Chanteigiah Collins and asked her why multiple witnesses said she was on the phone. She denied making a call, but acknowledged she was texting related to a personal family matter. She reported her first text was a 5:47pm and the last text was at 6:01 pm. She said she did not think Resident A was having a behavioral issue because they weren’t having problems with Resident A before she fell.

On 01/05/2022, I spoke by telephone with Ms. Torrey. I confirmed the telephone numbers of the staff. She explained that direct care staff, Cheyenne Perysian had put in her two weeks notice of leaving her job before this incident with Resident A. She said she had left very soon after the incident so she was uncertain if Ms. Perysian would talk with me. I called Ms. Perusian several times and left messages to call me back. At the writing of his report, I have not received a telephone call from Ms. Perysian.

On 01/26/2022, I conduced a telephone interview with direct care staff, Chanteigiah Collins. She confirmed that she worked second shift on 11/21/2021. She also confirmed that she had written a statement about what happened to Resident A who had fallen. She reported she was preparing dinner and she said she heard Resident A start crying before she fell. She stated "(Resident A) just walked to the door and the window and when I turned around, she just fell on her side to the floor. Then I heard her crying. I was not sure what was going on. I do not know what happened." She went on to say that there was a lot of commotion going on while she was preparing dinner. She acknowledged that she was on her phone. She also stated that she and her coworker could not get Resident A off the floor and into her chair. She explained that Resident A was not having any behaviors during this time. She said she did not know what happened to Resident A for her to fall the way she did. I asked her why she did not call 911 after Resident A fell and she stated she did not know what to do.

On 01/27/2022, Ms. Ann Meldrum the Licensee Designee, stated that somewhere in Resident A's history it was reported that she had weak ankles and she may have hurt them in the past. Ms. Meldrum explained that Resident A has always gotten up to see who has arrived in the driveway, therefore, it was not unusual for her to get up from the dining room table to see who had pulled into the driveway when Witness 1 arrived on 11/21/2021. Ms. Meldrum stated that the staff did call 911 and they did seek medical care treatment immediately. Both Ms. Meldrum reported that Resident A is a large woman weighting approximately 262 pounds. She also reported that Resident A would not be able to tell me to what happened when she fell, and she probably would not remember the incident. Ms. Meldrum reported that Resident A is in the hospital.

On 01/27/2022, I conducted an interview with Kassie Davis, PC, in the AFC home. She confirmed that she had written and signed her statement as to what had happened with Resident A on 11/21/2021. Her verbal statements were the same as her written statement. She did say when they pulled into the driveway of the home, she could hear Resident A screaming. She stated she tried to pick up Resident A from the floor and neither of the two staff working in the home, Ms. Collins, or Ms. Perysian, offered to help her. She stated that Ms. Collins was on her phone as she was in the kitchen.

On 01/27/2022, I received and reviewed Resident A's Health Care Appraisal, dated 07/16/2021. This reported stated that Resident A has "Moderate mental retardation,

Autistic, and a seizure disorder. I also reviewed Resident A's Treatment Plan/PCP which had been updated since her fall and surgery. She is now using a wheelchair and has a hospital bed with ¼ rails. She also has a walking boot. This document stated that she has dangerous actions including harm to self and harm to others. There was no mention of her throwing herself to the floor. I also reviewed her assessment plan signed on 11/12/2021. Staff are required to assist her with all of her personal care needs.

On 02/08/2022 I conducted a telephone exit conference with the Licensee Designee, Ann Meldrum and she agreed with my findings.

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:	Chanteigiah Collins, by her own admission, was on her phone with a non-work-related matter. Witness 1 and Kassie Davis reported she was on her phone making personal calls and or texting after Resident A had fallen and was crying out in pain. Cheyenne Perysian was not engaging with Resident A when Witness 1 arrived despite the obvious pain she (Resident A) was experiencing. Kassie Davis reported that she attempted to pick up Resident A from the floor and neither Ms. Collins or Ms. Perysian offered to help her and so she had to seek help from her boyfriend. Witness 1 and Kassie Davis both reported they could hear Resident A screaming and crying outside of the house while they were in the driveway. Resident A was screaming, crying and saying hospital and neither Ms. Perysian or Ms. Collins called any supervisor at the time Resident A fell nor did they call 911. They could not lift Resident A up from the floor to a chair. Ms. Perysian documented in her written signed statement that they just waited until the PC arrived. There is a preponderance of evidence that Resident A fell on 11/21/2021, was crying in pain, and she could not get up off the floor. Both staff, Ms. Perysian and Ms. Collins failed to respond

	in an appropriate way and failed to provide protection and safety or comfort for Resident A as she lay on the floor.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend that the Licensee provide an acceptable plan of correction and the license remain unchanged.

Arlene B. Smith 02/08/2022

Arlene B. Smith, MSW Date
Licensing Consultant

Approved By:

Jerry Hendrick 02/08/2022

Jerry Hendrick Date
Area Manager