GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 23, 2022

Carolyn Bruning
Northeast Michigan CMH Authority
400 Johnson Street
Alpena, MI 49707

RE: License #: AS040095845
Investigation #: 2022A0360014
Princeton Home

Dear Ms. Bruning:

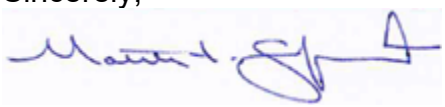
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (989) 732-8062

Sincerely,



Matthew Soderquist, Licensing Consultant
Bureau of Community and Health Systems
Ste 3
931 S Otsego Ave
Gaylord, MI 49735
(989) 370-8320

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS040095845
Investigation #:	2022A0360014
Complaint Receipt Date:	01/31/2022
Investigation Initiation Date:	01/31/2022
Report Due Date:	03/02/2022
Licensee Name:	Northeast Michigan CMH Authority
Licensee Address:	400 Johnson Street Alpena, MI 49707
Licensee Telephone #:	(989) 358-7603
Administrator:	Nicole Kaiser
Licensee Designee:	Carolyn Bruning
Name of Facility:	Princeton Home
Facility Address:	215 Princeton Alpena, MI 49707
Facility Telephone #:	(989) 356-9318
Original Issuance Date:	06/26/2001
License Status:	REGULAR
Effective Date:	03/06/2020
Expiration Date:	03/05/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A was put to bed with her leg braces and shoes on and her safety mat was not placed next to her bed.	Yes

III. METHODOLOGY

01/31/2022	Special Investigation Intake 2022A0360014
01/31/2022	Special Investigation Initiated - Telephone Jolie Danielson NEMCMH ORR
02/02/2022	Inspection Completed On-site Resident A, Jolie Danielson, DCS Nichole Orlowski, Home manager Cheryl Romel
02/17/2022	Inspection Completed On-site Resident A, DCS Cathy Rinard
02/22/2022	Contact - Document Received Jolie Danielson ORR
02/23/2022	Exit Conference With licensee designee Carolyn Bruning

ALLEGATION: Resident A was put to bed with her leg braces and shoes on and her safety mat was not placed next to her bed.

INVESTIGATION: On 1/31/2022 I was assigned a complaint from the LARA online complaint system.

On 1/31/2022 I contacted Jolie Danielson, recipient rights officer with Northeast Michigan Community Mental Health. Ms. Danielson stated she could meet at the facility on 2/02/2022.

On 2/02/2022 I conducted an onsite inspection at the facility with Ms. Danielson. I interviewed direct care staff Nichole Orlowski. Ms. Orlowski stated on 1/24/2022 she was working at the home with direct care staff Cathy Rinard. She stated in the early afternoon Ms. Rinard put Resident A down for a nap. She stated per Resident A's individual plan of service she is supposed to have her leg orthotics removed and a pad placed on the floor to prevent injury in case Resident A were to fall out of bed. She stated she went into the room to get Resident A's roommate out of bed and the mattress pad was not on the floor and Resident A was still wearing her leg orthotics

and shoes. I then interviewed the home manager Cheryl Romel. Ms. Romel provided a copy of Resident A's written assessment plan and individual plan of service which included an addendum that outlined accommodations and support for safety. The accommodations and support for safety noted that Resident A requires a bolster pad on her bed and a floor mat must be used to prevent injury if Resident A should fall out of bed. It also noted that Resident A uses bilateral ankle-foot-orthosis supports (AFO's). Resident A was observed in the home however due to limited verbal skills she was unable to be interviewed. Ms. Romel stated Resident A did not fall out of bed on 1/24/2022 and despite her AFO's not being removed she did not suffer any marks or soreness on her feet or legs from not having them removed during her nap. I then observed Resident A's bed and mattress pad.

On 2/17/2022 I conducted another onsite inspection at the facility. I interviewed direct care staff Cathy Rinard. Ms. Rinard stated she was busy on 1/24/2022 and put Resident A down for her nap. She stated she did not remove Resident A's AFO's or shoes. She stated in hindsight she should have taken them off. She stated she did put Resident A's pad on the floor however she thinks that it was moved when Resident A's roommate was woken up from their nap because they require a lift, and the lift will not maneuver in the room with Resident A's pad on the floor. Ms. Rinard stated Resident A was not hurt and did not suffer any redness or soreness on her legs due to not having her AFO's removed. She stated they always remove them and this was the only day they were not removed when Resident A was put down for a nap.

On 2/22/2022 I was contacted by rights officer Jolie Danielson. Ms. Danielson stated that she reviewed Resident A's Health Maintenance Program dated 11/24/2021 which stated that Resident A's AFO's were to be off while in bed due to skin irritation and comfort measure. Ms. Danielson stated she will be substantiating a rights violation due to the AFO's not being removed while Resident A was in bed.

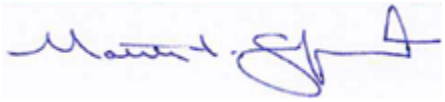
APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	The complaint alleged Resident A was put to bed with her leg braces and shoes on and her safety mat was not placed next to her bed. Resident A was placed in bed for a nap on the afternoon of 1/24/2022 and her AFO's and shoes were not removed. Resident A's written assessment plan and individual plan of service note that Resident A requires the use of AFO's and her

	health maintenance program documents that the AFO's should be removed while Resident A is in bed due to comfort measures and skin irritation. There is a preponderance of evidence that Resident A was not provided supervision, protection and personal care as outlined in her written assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 02/23/2022 I conducted an exit conference with the licensee designee Carolyn Bruning. Ms. Bruning stated she would submit a corrective action plan for approval.

IV. RECOMMENDATION

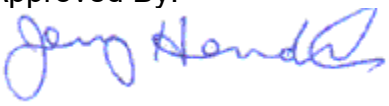
Upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.



02/23/2022

Matthew Soderquist Date
Licensing Consultant

Approved By:



02/23/2022

Jerry Hendrick Date
Area Manager