GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 8, 2022

Frances Wagner
Northern Pathways
12700 Lincoln Lake Ave.
Gowen, MI 49326

RE: License #: AS410407255
Investigation #: 2022A0357015
Northern Pathways 2

Dear Ms. Wagner:

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.
matter.

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 #:	AS410407255
Investigation #:	2022A0357015
Complaint Receipt Date:	04/13/2022
Investigation Initiation Date:	04/13/2022
Report Due Date:	06/12/2022
Licensee Name:	Northern Pathways
Licensee Address:	12700 Lincoln Lake Ave. Gowen, MI 49326
Licensee Telephone #:	(616) 560-7455
Administrator:	Frances Wagner
Licensee Designee:	Frances Wagner
Name of Facility:	Northern Pathways 2
Facility Address:	12700 Lincoln Lake Ave. Gowen, MI 49326
Facility Telephone #:	(616) 712-6002
Original Issuance Date:	04/27/2021
License Status:	REGULAR
Effective Date:	10/26/2021
Expiration Date:	10/25/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A fell out of her wheelchair when she was transferring herself. She called for help, and no one came. There was no staff in the AFC home.	Yes
The medication cart was unlocked.	Yes

III. METHODOLOGY

04/13/2022	Special Investigation Intake 2022A0357015
04/13/2022	The referral came from APS. They had denied the complaint and had forwarded it to our Lansing office.
04/13/2022	Special Investigation Initiated - Telephone To Recipient Rights
04/13/2022	Contact – Telephone call received From the former Licensee, Rose Buck
04/14/2022	Contact - Telephone call received From Licensee Designee, Fran Wagner.
05/27/2022	Inspection Completed On-site Announced inspection at the facility.
05/27/2022	Contact - Face to Face Conducted interviews with: The Licensee Designee, Fran Wagner, Resident A, Resident B, and Resident C, and Family Member 1.
06/02/2022	Contact - Telephone call made Conducted a telephone interview with Deputy Chief of Oakfield Township Fire Department.
06/07/2022	Conducted a telephone exit conference with the Licensee Designee, Frances Wagner.

ALLEGATION: Resident A fell out of her wheelchair when she was transferring herself. She called for help, and no one came. There was no staff in the AFC home.

INVESTIGATION: The detailed allegation read as follows: *'(Resident A) is a 62-year- old living at an AFC. (Resident A) is wheelchair bound. It is unknown if (Resident A) has a POA or a Legal Guardian. Last night Emergency Services were called out to the AFC home after a client had fallen. (Resident A) was trying to transfer herself form her wheelchair to her bed and ended up falling. (Resident A) called 911. When Emergency Services got to the home it was discovered there was no caregiver in the home. The AFC home had to be broken into by Emergency Services. (Resident A) was located and assessed and put back into her wheelchair. There are six residents in the home and not care giver was present. The home medication box was also unlocked, and the residents had access to it.'*

On 05/27/2022, I made an announced inspection of the facility. I conducted a face-to-face interview with Resident A. She reported that while trying to get to the bathroom around 11:00 PM she slipped out of her chair. Resident A stated she then "called Fran" and yelled for help, but no one came. Resident A stated she then called 911 and the "emergency people" let themselves in, picked her up, helped her into her chair and they asked her if she was hurt. Resident A stated she told them she was okay. She reported that after they picked her up from the floor they left. I asked her if this had happened before, and she said no, this was the first time it happened. She stated she did not know the date of the event. She stated she was not hurt but she could not pick herself up off the floor. She stated she uses her wheelchair to get around. She stated she has lived in this AFC home since August of 2021, likes the home, and has no complaints.

On 05/27/2022, I interviewed Resident B and Resident C and they both reported they had no memory of Frances Wagner not being in the home or that Resident A fell from her wheelchair. They had no memory of being left without staff since they have lived in the home. Due to Resident D's disability, I was unable to interview him.

On 05/27/2022, I conducted a face-to-face interview with Licensee Designee, Frances Wagner. She stated that the date this incident occurred was a Tuesday in April 2022. She thought it was on 04/12/2022 to 04/13/2022 but she was uncertain. She reported that there were four residents in the facility. She acknowledged that she was working the shift 8:00 PM until 8:00 AM and she was the only staff on duty for that shift. She explained that her uncle had become very ill, and he was in a hospital at Spectrum Butterworth in ICU. Ms. Wanger reported that her uncle called her and asked her to come to see him because he thought he was dying. She stated that she thought that she would not be able to see him again before he died. She explained further that her aunt was on her way to Ms. Wanger's AFC home and was very close and had reported she would be to the AFC home in three to four minutes. Ms. Wagner said she had decided to get into her car and was in the driveway when her aunt tried to call her again. Ms. Wagner reported that the cell service is spotty where her aunt was. She said her aunt had tried to call her several times. Ms. Wagner stated that because she believed her aunt was only to three to four minutes away, she left the AFC home and began driving to the hospital. I asked her the time and she thought it was between 11:30 PM to 12:00 midnight. She said she was on

the highway when her aunt called her again and this time, she did receive the call and her aunt reported that her truck had overheated, and she had to pull to the side of the road. Ms. Wanger stated that she turned around and headed back to the home. Ms. Wagner reported that she arrived back at the AFC home and there was an ambulance and police car at the facility. She stated that they explained to her that Resident A had fallen out of her wheelchair and had called 911 since she could not reach any staff. She said they reported to her that Resident A was not hurt. She said they told her they picked Resident A up and put her back into her chair. She stated that she explained to the ambulance personnel what had happened. She stated that her aunt arrived shortly after she had returned to the AFC home. Ms. Wagner reported that this was an emergency, and she was planning that her aunt would have stayed with the residents in the AFC home while she went to the hospital to see her uncle before he died. I asked Ms. Wagner how long she thought she was gone from the AFC home, and she stated, “from 30 to 45 minutes.” She stated she could not find anyone else to come to the AFC home to stay with the residents in the minutes she had before she left for the hospital. I asked her about her front door, and she reported that the police did not knock down her front door. Ms. Wagner was very remorse full and apologized for leaving the residents unsupervised.

On 05/27/2022, I conducted a face-to-face interview with Ruthann Stevens, Ms. Wagner’s aunt. She acknowledged that her husband became very ill and was hospitalized at spectrum Blodgett ICU. She repeated the same story that Ms. Wagner had provided. She confirmed she was driving to Ms. Wagner’s AFC home, and her cell phone did not work, and then her truck overheated, and she had to pull off the road to let the truck cool down. She said she did finally make it to Ms. Wagner’s AFC home after Ms. Wagner had arrived.

On 05/27/2022, I reviewed Resident A’s assessment plan. There was no mention of an assessed concern regarding Resident A sliding out of her wheelchair.

On 06/02/2022, Iconducted a telephone interview with Deputy Chief of Oakfield Township Fire Department (Witness 1). He stated that the call came in on 04/13/2022 and he departed from their office at 23:40 hours and he arrived at the AFC home at 23:53 hours. He stated that it was an unknow caller. When he arrived at the facility the front door was locked and he knocked at the door several times, but no one came to the door. He said he called back to Dispatch to verify the address. When Dispatch called the original number of the caller back it went directly to voice mail. He stated that he was concerned that it was a non-emergency call and therefore it could be false. Witness 1 stated that any time he has gone to an AFC home staff always come to the door after they knock. He reported he saw a light on in the basement, so he walked around and checked the door to the basement, and it opened. He reported that he did not find anyone on the lower level, so he checked the perimeter of the home and did not find anyone. He said he went upstairs, and the medics were on their way into the home, and they found Resident A sitting on the floor and she stated she was not hurt. He stated the police had arrived and an officer went to the other house on the property (which is licensed as an AFC home)

and banged on the door and then a girl came running over asking what had happened. He stated after ½ hour they were able to connect with Frances Wagner who was the person who was to be in the facility. He reported she came back before they left. Witness 1 stated they cleared the scene on 04/14/2022 at 1:15 AM.

On 06/07/2022, I conducted a telephone exit conference with the Licensee Designee, Frances Wagner and she said she agreed with my findings.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Resident A fell out of her wheelchair when she was transferring herself. She called for help, and no one came. There were no staff in the AFC home. In addition to Resident A, there were three other residents living in the AFC home. Resident A reported that she had slipped out of her wheelchair and was on the floor and she called for Frances Wagner but there was no answer, so she dialed 911 on her phone. The Licensee Designee, Francis Wagner acknowledged she had left the home to go see her uncle. Her aunt was on her way to relieve her but her truck overheated. Ms. Wagner acknowledged she was gone from the home for 30 to 45 minutes and that she was the only staff on duty. The Deputy Chief of Oakfield Township Fire Department stated he went to the home and there were no staff in the home and Resident A was on the floor. There is a preponderance of evidence to confirm that there were not any staff on duty in the home when Resident A slipped out of her wheelchair and onto the floor. Therefore, a violation is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	The Licensee Designee, Frances Wagner was working on shift and she chose to leave the facility, leaving residents unsupervised. She acknowledged that there was no staff in the home. Resident A slipped out of her wheelchair and onto the floor. Resident A called 911 to seek help to be lifted off of the floor. Resident A's personal needs including protection and safety were not attended to when she slipped out of her wheelchair and onto the floor and there were no staff present to help her back into her wheelchair.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: The medication cart was left unlocked.

INVESTIGATION: On 06/02/2022, I conducted a telephone interview with Deputy Chief of Oakfield Township Fire Department (Witness 1). He stated that the medics found the medication cart was unlocked and stated that any resident could have gotten into the medication cart. After they brought it to his attention, he also observed the same medication cart unlocked. He stated the cart holds the resident's medication.

On 06/07/2022, I conducted an exit conference by telephone with the Licensee Designee, Frances Wagner. Ms. Wagner stated that the staff before her left the door to the medication room unlocked. She stated that the staff told her she forgot to lock the room. She agreed with my findings.

APPLICABLE RULE	
R 400.14312	**Resident medication.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, take, or applied only as a prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specific resident in accordance

	with the requirements of Act No. 368 of the Public Acts of 1978, as amended being S333. 1101 et seq. of the Michigan Complied Laws, kept with the equipment of administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Witness 1 verified the medication cart in the home was unlocked and therefore accessible to the residents who reside in the AFC home.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend the Licensee Designee provide an acceptable plan of correction and the license will remain the same.

Arlene B. Smith 06/08/2022

Arlene B. Smith, MSW Date
Licensing Consultant

Approved By:

Jerry Hendrick 06/08/2022

Jerry Hendrick Date
Area Manager