GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 29, 2022

Gwen Williams
CMHB Of CEI Counties
Suite 115
812 E Jolly Road
Lansing, MI 48910

RE: License #: AL330079965
Investigation #: 2022A0783044
Bridges Crisis Unit (AFC)

Dear Ms. Williams:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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) 284-9730.

Sincerely,

Leslie Herrguth

Leslie Herrguth, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 256-2181

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL330079965
Investigation #:	2022A0783044
Complaint Receipt Date:	05/31/2022
Investigation Initiation Date:	06/02/2022
Report Due Date:	07/30/2022
Licensee Name:	CMHB Of CEI Counties
Licensee Address:	Suite 115 812 E Jolly Road Lansing, MI 48910
Licensee Telephone #:	(517) 346-8200
Administrator:	Gwen Williams
Licensee Designee:	Gwen Williams
Name of Facility:	Bridges Crisis Unit (AFC)
Facility Address:	812 E Jolly Rd Lansing, MI 48910
Facility Telephone #:	(517) 346-8415
Original Issuance Date:	06/04/1999
License Status:	1ST PROVISIONAL
Effective Date:	02/01/2022
Expiration Date:	07/31/2022
Capacity:	16
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A, who was court – ordered to receive treatment and medication was not properly supervised at the facility and he eloped from the facility on May 31, 2022.	No
Resident A refused to take his prescribed medication for three days and the appropriate health care professional was not contacted.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/31/2022	Special Investigation Intake – 2022A0783044
05/31/2022	Contact - Document Received – *Written AFC Licensing Division Incident/Accident Report* for Resident A
05/31/2022	Contact - Document Received – Email message from facility coordinator Tonya Randall
06/02/2022	Special Investigation Initiated - On Site
06/02/2022	Inspection Completed On-site
06/02/2022	Contact - Face to Face interview with facility coordinator Tonya Randall
06/02/2022	Contact - Face to Face interview with facility nurse Jerri Upright
06/02/2022	Contact - Face to Face interviews with direct care staff members Jodi Johnson and Keisha McCall
06/02/2022	Contact - Document Received – Resident A's written resident record
06/24/2022	Contact - Telephone call made to Tonya Randall
06/24/2022	Contact - Telephone call made to direct care staff member Daniel Rapelje

07/01/2022	Contact - Telephone call made to direct care staff member Brittany Davis
07/07/2022	Contact - Telephone call made to facility nurse Rebecca Krasnoselsky
07/12/2022	Contact - Telephone call made to direct care staff member Jillane Biernacki
07/26/2022	Contact - Telephone call made to CMH Court Liaison Christy Granger
7/26/2022	Exit Conference with Gwen Williams

ALLEGATION:

Resident A, who was court – ordered to receive treatment and medication was not properly supervised at the facility and he eloped from the facility on May 31, 2022.

INVESTIGATION:

On May 31, 2022, I received a written *AFC Licensing Division Incident/Accident Report* dated May 31, 2022, that stated Resident A reported he was leaving the facility and then left. The written report stated staff members "tried to deescalate and discuss options," and that after Resident A left, law enforcement and court liaisons were contacted, and a non-compliance order was drafted and provided to crisis services. There was no corrective measure indicated on the written report.

On May 31, 2022, I received a written email message composed by facility coordinator Tonya Randall that stated when Resident A left the facility a staff member did not follow Resident A but contacted law enforcement to report his elopement. Ms. Randall stated if police locate Resident A, he will be taken to crisis services to determine what level of care is needed at that time. Ms. Randall stated the corrective action for the elopement is to "file non-compliance order sooner to ensure accurate level of care and follow court order specifications."

On June 2, 2022 and June 24, 2022, I spoke to Tonya Randall who stated that Resident A was admitted to the facility on May 20, 2022, per a written court order and that he "withdrew" from the facility against medical advice on May 31, 2022. Ms. Randall stated Resident A did not have a guardian or authorized representative to make decisions on his behalf. Ms. Randall said Resident A walked out the door near the nurses' station and direct care staff members working were aware Resident A left the facility and telephoned police before Resident A left the facility because Resident A's treatment at the facility was court–ordered. Ms. Randall said that

although Resident A refused to take his prescribed medications for three days a written order of noncompliance was not generated and submitted to the probate court until Resident A left the facility. Ms. Randall stated prior to completing a written order of noncompliance Resident A's treatment team was to convene and attempt to implement other potential solutions. Ms. Randall explained that Resident A was stable and there was no change in his behavior until May 31, 2022, which is when the order of noncompliance was completed. Ms. Randall stated Resident A required baseline supervision at the facility, so direct care staff members made visual contact with Resident A at least every two hours. Ms. Randall said Resident A was within staff members' line of sight when he walked out the door with his belongings on May 31, 2022, and that staff members were on the telephone with law enforcement before Resident A even left the facility.

On June 2, 2022, I spoke to facility nurse Jerri Upright who stated she was working on May 31, 2022, when Resident A left the facility. Ms. Upright said she spoke with Resident A at approximately 11:30 am on May 31, 2022, and that he told her he was leaving the facility. Ms. Upright said as she spoke to Resident A, he was packing his belongings. Ms. Upright said she attempted to redirect Resident A, but Resident A chose to withdraw from treatment against medical advice and left the facility with a bag of his belongings via a door near the nurses' station at approximately 11:30 am. Ms. Upright stated Resident A required baseline supervision every two hours which he received at the facility. Ms. Upright said direct care staff member Keisha McCall telephoned police to inform them that Resident A withdrew from treatment against medical advice before Resident A even left the building. Ms. Upright said since Resident A was court–ordered to the facility for treatment an order of noncompliance was drafted and submitted as well.

On June 2, 2022, and July 25, 2022, I spoke to direct care staff member Keisha McCall who stated her title at the facility is client service specialist and that she was assigned to monitor Resident A on May 31, 2022. Ms. McCall said Resident A was admitted to the facility as a step–down from an inpatient hospital where he received psychiatric treatment and that he was court–ordered to receive treatment at the facility. Ms. McCall said Resident A was cooperative with treatment for approximately a week and then began refusing to take his medication. Ms. McCall said Resident A required baseline supervision inside the facility and staff members made visual contact with Resident A at least every two hours. Ms. McCall said on May 31, 2022, Resident A stated he wanted to leave the facility which was the first time Resident A ever indicated he was considering withdrawing from treatment against medical advice. Ms. McCall said she attempted to verbally redirect Resident A, but he refused to have a conversation with her. Ms. McCall said Resident A told her he was leaving, packed a bag of belongings and walked out the door near the nurses' station. Ms. McCall said she telephoned police to notify them that Resident A was leaving the facility against medical advice before he left and since Resident A was court–ordered to receive treatment at the facility she completed an order of noncompliance and submitted it to the probate court. Ms. McCall stated that although Resident A was court – ordered to take medication she did not draft a

written order of noncompliance and issue it to the court until it became clear that Resident A was a danger to himself, others, or/or property when he left the facility.

On June 2, 2022, I spoke to direct care staff member Jodi Johnson who stated she was present when Resident A left the facility. Ms. Johnson said Resident A required baseline supervision wherein direct care staff members made visual contact with Resident A at least every two hours. Ms. Johnson said she met with Resident A earlier in the morning on May 31, 2022, and Resident A was “in good spirits.” Ms. Johnson said Resident A made no mention of wanting to leave the facility prior to leaving on May 31, 2022, and that she was “surprised” that he left.

On June 24, 2022, I spoke to direct care staff member Daniel Rapelje who said he worked with Resident A in the days leading up to May 31, 2022, when Resident A left the facility. Mr. Rapelje said Resident A was cooperative and seemed to be “planning for” a traditional discharge and never mentioned that he was considering leaving the facility against medical advice. Mr. Rapelje said another direct care staff member telephoned police when Resident A left the facility because he was court–ordered to be at the facility. Mr. Rapelje stated Resident A did not have any specific supervision needs inside the facility and that Resident A was visually monitored at least every two hours.

On July 1, 2022, I spoke to direct care staff member Brittany Davis who stated she worked with Resident A in the days leading up to May 31, 2022, when Resident A left the facility. Ms. Davis stated Resident A never mentioned anything about leaving the facility prior to a planned discharge. Ms. Davis said since Resident A was court–ordered to receive mental health treatment at the facility a direct care staff member notified police when Resident A left the facility. Ms. Davis said Resident A required baseline supervision within the facility which required staff members to make visual contact with Resident A at least every two hours.

On July 12, 2022, I spoke to direct care staff member Jillane Biernacki who said she worked with Resident A in the days leading up to his departure from the facility on May 31, 2022 and that she did not recall Resident A stating anything about leaving the facility prior to a planned discharge. Ms. Biernacki stated police were notified when Resident A left the facility because he was court–ordered to receive treatment. Ms. Biernacki stated Resident A required baseline supervision within the facility and that he was visually monitored at least every two hours at the facility.

On July 26, 2022, I spoke to licensee designee and administrator Gwen Williams who said Resident A was court–ordered for treatment at the facility and that the purpose of Resident A’s admission to the facility was to coordinate outpatient services for Resident A who is now working with a CMH assigned case manager to help meet his needs. Ms. Williams said Resident A required baseline supervision within the facility and that throughout his admission until the day he chose to leave the facility, Resident A presented as “stable” and that his behavior remained consistent which is why the probate court was not notified immediately that Resident

A was noncompliant with medications. Ms. Williams stated when Resident A left the facility against medical advice it became evident that he was a potential danger to himself, others, and/or property. Ms. Williams stated staff member Keisha McCall notified police that Resident A was leaving the facility before Resident A left and completed a written order of noncompliance which was submitted to the probate court the same day. Ms. Williams stated Resident A is presently connected with a CMH case manager and is receiving outpatient treatment.

On July 26, 2022 I spoke to CMH court liaison Christy Granger who said when a resident is court ordered to participate in treatment at the facility and the resident becomes non-compliant with treatment and thus the court order, such as Resident A did when he refused to take his medication May 28, 2022 – May 31, 2022, the first step is for the treatment team to identify the reason behind the resident's noncompliance and implement solutions. Ms. Granger said it is not the probate judge's expectation nor is it feasible that the court be notified immediately of every resident who is medication noncompliant. Ms. Granger stated when an order of noncompliance is filed with the court the expectation is that the resident is a danger to themselves, others, and/or property. Ms. Granger stated the local resources are not available to hospitalize every resident who is medication noncompliant even if court-ordered. Ms. Granger stated if a resident refuses to take his/her court-ordered medication but remains stable an order of noncompliance should not be completed.

On June 2, 2022, I received and reviewed a written document entitled *Initial Order After Hearing On Petition For Mental Health Treatment* concerning Resident A and dated May 4, 2022. The written court order stated, "By clear and convincing evidence, [Resident A] is a person requiring treatment because the individual has mental illness, and as a result of that mental illness can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure self or others and has engaged in an act or acts or made significant threats that are substantially supportive of this expectation." The written order stated, "[Resident A] shall receive combined hospitalization and assisted outpatient treatment for no longer than 180 days. The individual shall be hospitalized for up to 60 days of the 180 – day assisted outpatient treatment period." The written report stated Clinton Eaton Ingham Community Mental Health (CEICMH) was responsible for managing Resident A's assisted outpatient treatment. The written order stated "if the individual refuses to comply with a psychiatrist's order for hospitalization, a peace officer shall take the individual into protective custody and transport the individual to the hospital designated by the psychiatrist."

On June 2, 2022, I received a reviewed a document entitled *Notification of Noncompliance* signed by direct care staff member Keisha McCall and dated May 31, 2022. The document stated, "Client refused medications on Tuesday May 31, 2022. Client said that it is staff who are delusional. Client had withdrawn from treatment by leaving the Bridges Crisis Unit." The written document stated Resident A was not complying with the order for assisted outpatient treatment and that

Resident A needed immediate hospitalization per the psychiatrist who originally assessed Resident A as he was noncompliant with assisted outpatient treatment.

On June 2, 2022, I received and reviewed a *Nursing Note* for Resident A dated May 31, 2022 and electronically signed by facility nurse Jerri Upright at 11:44 am. The note stated, "[Resident A] is insistent that [the facility] is not helpful and he is going to leave. We talked about this briefly, he is adamant he is leaving. [Client Service Specialist] is notified so she can talk with same for need to do [order of noncompliance] or let go. Patient packing belongings at this time."

On July 18, 2022, I received and reviewed written *Shift Logs* for Resident A for May 31, 2022. The written log indicated it was concerning May 31, 2022, from 8:00 am to 4:00 pm and stated, "[Resident A] had been self structured and observed in the main areas during this shift. Client had eaten breakfast this morning before withdrawing from treatment and leaving Bridges Crisis Unit. A Notification of Noncompliance, the P.R.T. background envelope and the Protected Personal Identifying Information was completed and submitted to court liaison. The Lansing Police Department was called for an attempt to locate and to inform of the client's current court order."

On June 2, 2022, I received a written email message documenting facility nurse Jerri Upright notified the proper individual at Community Mental Health (CMH), which was Resident A's responsible agency.

On June 2, 2022, I received and reviewed Resident A's written *Assessment Plan for AFC Residents* dated May 20, 2022 and signed by Resident A. There was no guardian or designated representative identified on the written assessment. The written assessment indicated Resident A moved independently in the community and did not indicate that he had any specific supervision needs within the facility.

On June 2, 2022, I received and reviewed Resident A's *Treatment Plan* dated May 20, 2022. The written plan stated, "on a daily basis the BCU staff will monitor and document your mental status, sleep, appetite, hygiene, and social interactions." There were no further or specific instructions or requirements concerning Resident A's supervision needs within the facility.

APPLICABLE RULE	
R 400.15303	**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:	Based on statements from Ms. Randall, Ms. Upright, Ms. McCall, Mr. Rapelje, Ms. Davis, and Ms. Biernacki and the written documentation at the facility Resident A required supervision every two hours within the facility where was court ordered to receive treatment and medication, which he received. Though Resident A was medication noncompliant for two days prior to leaving the facility against medical advice on May 31, 2022, he was assessed during that time to not be a danger to himself, others, and /or property so an order of noncompliance was not submitted for Resident A simply refusing to take his medication on May 29 – 30, 2022. This is in part due to a lack of resources and Resident A could not be hospitalized simply for refusing to take his medication for two days. Upon Resident A's decision to leave the facility on May 31, 2022, it was determined that Resident A was a danger to himself, others, and/or property and the proper authorities were notified that Resident A was noncompliant with a court order.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(3) If a resident is absent without notice, the licensee or direct care staff shall do both of the following: **(a) Make a reasonable attempt to contact the resident's designated representative and responsible agency.** **(b) Contact the local police authority.**

ANALYSIS:	Based on statements from Ms. Randall, Ms. Upright, Ms. McCall, Mr. Rapelje, Ms. Davis, Ms. Biernacki, Ms. Granger, and Ms. Williams as well as written documentation at the facility I determined that Resident A was absent without notice when he left the facility on May 31, 2022, and staff members took the correct steps which are to contact the local police authority along with Resident A's designated representative and responsible agency. Resident A did not have a designated representative and the police and CMH were notified. Staff members were aware that Resident A left and notified police before Resident A left the facility. Staff members followed up appropriately by completing the *Order of Noncompliance* and issuing the document to the proper authorities.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A refused to take his prescribed medication for three days and the appropriate health care professional was not contacted.

INVESTIGATION:

On May 31, 2022, I received a written *AFC Licensing Division Incident – Accident Report* concerning Resident A dated May 31, 2022, that stated, "Client is court ordered to take medication. Client has refused since 5/28/22. Client reported that making him take his medication is a violation of his rights."

On June 2, 2022, I spoke to facility coordinator Tonya Randall who said Resident A was admitted on May 20, 2022 and that he was compliant with taking his medication until Saturday May 28, 2022. Ms. Randall said when a resident refuses medication the facility nurse who attempted to administer the medication documents in writing that the resident refused the medication, makes efforts to speak to the resident to educate him/her about the medication and to understand why the resident will not take the medication. Ms. Randall said she was not certain if Resident A was established as a patient with any primary care physician. Ms. Randall said she was not certain if the nurses who attempted to administer Resident A's medication followed up with Resident A's assigned health care professional when Resident A refused to take medication multiple times May 28, 2022 – May 31, 2022.

On July 7, 2022, I spoke to facility nurse Rebecca Krasnoselsky who stated she worked May 28 – May 30, 2022 and was responsible for administering medication to Resident A. Ms. Krasnoselsky said Resident A refused to take his prescribed court–ordered medication from May 29, 2022 – May 30, 2022. Ms. Krasnoselsky said she

did not notify Resident A's assigned health care professional such as his physician or pharmacist because she did not note a change in his mental status. Ms. Krasnoselsky said since Resident A was "stable, getting up and showering and eating," she did not note a reason to contact his physician to provide notification and receive instructions about Resident A refusing to take his medication. Ms. Krasnoselsky said she regularly monitored Resident A and checked his vital signs which were within normal range.

On June 2, 2022, I spoke to facility nurse Jerri Upright who stated she worked on Monday May 31, 2022 and was responsible for administering medication to Resident A. Ms. Upright stated on May 31, 2022 Resident A told her it was in his treatment plan for him to stop taking all medications and she advised him that he was court–ordered to take the medication but Resident A ultimately refused to take the medication. Ms. Upright said she contacted Resident A's assigned social worker through Community Mental Health (CMH) and notified her that Resident A refused to take his court–ordered prescribed medication. Ms. Upright stated she did not contact Resident A's assigned health care professional such as his physician or pharmacist to provide notification that Resident A refused to take his medication on May 31, 2022.

On July 12, 2022, I spoke to direct care staff member Jillane Biernacki who said she administers medication as part of her job responsibilities when there is no facility nurse available to administer the medication. Ms. Biernacki said if a resident refuses to take his/her medication she would note the refusal in the resident's written record which would be seen by the facility nurse. Ms. Biernacki said she does not contact any residents' physician or pharmacist upon a medication refusal.

On July 26, 2022, I spoke to licensee designee and administrator Gwen Williams who said the physician who prescribed Resident A's medication was no longer treating Resident A and that notifying the pharmacist would not have been productive so the facility nurse care manager was notified that Resident A refused to take his medication. Ms. Williams said CMH representatives believed the facility nurse care manager is the appropriate health care professional to contact for a resident admitted to the facility. Ms. Williams said Resident A was monitored and that he was not noted to have exhibited any changes during the three days that he refused to take his medication.

On June 2, 2022, I received and reviewed Resident A's medication administration record (MAR) from May 20, 2022, when he was admitted to the facility until May 31, 2022, when he discharged from the facility. I noted that according to the written MAR Resident A refused to take his prescribed Invega ER, 3 mg, 1 tab daily on May 29, 2022 and May 30, 2022. The person who documented the refusals was facility nurse Rebecca Krasnoselsky. There was no record that Resident A took nor refused his prescribed Invega on May 31, 2022, rather the MAR is blank.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: (f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.
ANALYSIS:	Based on statements from Ms. Randall, Ms. Upright, Ms. Krasnoselsky, Ms. Biernacki, and Ms. Williams I determined it is not facility practice to notify a resident's health care professional when a resident refuses medication. Further, based on verbal statements from the individuals responsible for administering Resident A's prescribed court – ordered medication they did not notify the appropriate health care professional familiar with Resident A, including the nurse care manager, that Resident A refused to take his prescribed medication May 28, 2022 – May 31, 2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

When I spoke to facility nurse Jerri Upright on June 2, 2022, she stated Resident A refused to take his prescribed Invega ER, 3 mg, 1 tab daily on May 31, 2022.

On June 2, 2022, I received a reviewed a document entitled *Nursing Note* for Resident A which was dated May 31, 2022 and electronically signed by Jerri Upright. The document stated Resident A had been refusing medication since May 28, 2022.

On June 2, 2022, I received and reviewed a *Notification of Noncompliance* signed by staff member Keisha McCall that stated Resident A refused to take his medication on May 31, 2022.

On June 2, 2022, I received and reviewed MAR for Resident A and noted that on May 31, 2022, there is nothing noted at all to indicate if Resident A took the medication or refused to take the medication. The MAR is blank for Invega ER on May 31, 2022.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication was given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	Based on a statement from Ms. Upright and written documentation at the facility it appears that on May 31, 2022, Resident A refused to take his medication. There were no initials indicating that Ms. Upright administered the medication and there was no documentation that Resident A refused to take the medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Due to the facility being on a 1st provisional license because of the violations established in special investigation report 2021A0466043 dated October 8, 2021, and the quality of care related violations established in this report, I recommend revocation of the license.

Leslie Herrguth 07/27/2022

Leslie Herrguth Date
Licensing Consultant

Approved By:

Dawn Timm 07/27/2022

Dawn N. Timm Date
Area Manager