GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 27, 2023

James Pilot
Bay Human Services, Inc.
P O Box 741
Standish, MI 48658

RE: License #:	AS060068988
Investigation #:	2023A0123017
	Almont AFC

Dear Mr. Pilot:

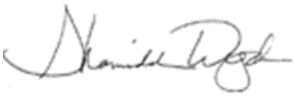
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

If you desire technical assistance in addressing these issues, please feel free to 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 (517) 643-7960.

Sincerely,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS060068988
Investigation #:	2023A0123017
Complaint Receipt Date:	01/03/2023
Investigation Initiation Date:	01/05/2023
Report Due Date:	03/04/2023
Licensee Name:	Bay Human Services, Inc.
Licensee Address:	PO Box 741 3463 Deep River Rd Standish, MI 48658
Licensee Telephone #:	(989) 846-9631
Administrator:	Tammy Unger
Licensee Designee:	James Pilot
Name of Facility:	Almont AFC
Facility Address:	140 Almont Street Standish, MI 48658
Facility Telephone #:	(989) 846-9648
Original Issuance Date:	08/01/1996
License Status:	REGULAR
Effective Date:	02/01/2021
Expiration Date:	01/31/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 12/25/2022, staff Harley Whitney failed to provide report regarding Resident A's need for emergent transport and care at St. Mary's Emergency Department due to high potential for a blood clot. The care provided to Resident A was markedly delayed due to the lack of communication from Staff Whitney.	Yes
On 01/01/2023, Staff Jenna Lachcik discovered Resident A was given medications that were previously on hold due to a medical procedure she was supposed to have done on 01/03/2023. Management failed to note the medication that were still supposed to be held on January's medication administration records. Due to the med sheets not being properly reconciled, Resident A was not able to have a medical procedure as scheduled.	Yes

III. METHODOLOGY

01/03/2023	Special Investigation Intake 2023A0123017
01/03/2023	APS Referral Information received regarding denied APS referral.
01/05/2023	Contact - Telephone call made I left a voicemail requesting a return call from recipient rights investigator Kevin Motyka.
01/05/2023	Contact - Document Sent I sent an email to Resident A's public guardian.
01/05/2023	Special Investigation Initiated - Telephone I spoke with Melissa Prusi of recipient rights.
01/12/2023	Inspection Completed On-site I conducted an on-site inspection at the facility.
01/23/2023	Contact - Telephone call made I interviewed staff Harley Whitney via phone.
01/23/2023	Contact - Telephone call made I left a voicemail requesting a return call from staff Thelma Davis.
01/23/2023	Contact - Telephone call made I interviewed BABHA nurse Linda Thomas, RN.

1/26/2023	Contact- Telephone call made I left a message requesting a return call from staff Joe Krystyniak.
01/26/2023	Contact- Telephone call received I interviewed staff Joe Krystyniak via phone.
01/26/2023	Contact- Telephone call made I attempted to contact staff Thelma Davis. There was no answer.
01/27/2023	Exit Conference I spoke with licensee designee Joe Pilot via phone.

ALLEGATION: On 12/25/2022, staff Harley Whitney failed to provide report regarding Resident A's need for emergent transport and care at St. Mary's Emergency Department due to high potential for a blood clot. The care provided to Resident A was markedly delayed due to the lack of communication from Staff Whitney.

INVESTIGATION: On 12/27/2022, two *AFC Licensing Division- Incident/Accident Report* were received faxed.

The incident report dated 12/25/2022 at 7:00 am states that Resident A woke up and told staff Joe Krystyniak that she could not feel her leg. Staff Krystyniak evaluated her legs and determined it was Resident A's right leg. Staff Krystyniak contacted the home manager and the on-call nurse. Staff called 911 to have an ambulance transport Resident A to the emergency room to be evaluated. The incident report further states that Resident A was given a shot of blood thinner and was instructed to follow up the next day in the ER. Resident A was also prescribed a PRN for pain and an MRI was recommended to examine her leg.

The incident report dated 12/25/2022 at 12:00 pm stated that Resident A had pain in right foot and numbness. Staff called 911 and had Resident A transported to St. Mary's hospital in Saginaw. The hospital did an ultrasound of her right leg and x-rays. Resident A received a pain patch on the calf of her right leg and was given Tylenol around 2:00 pm. The incident report further notes that the primary care doctor was contacted for an update, hospital records were reviewed, and that there was no concern for anything urgently, but further discussion would be made the next day at a follow-up appointment on 12/28/2022.

On 01/05/2023, I spoke with recipient rights investigator Melissa Prusi via phone. She stated that staff Harley Whitney had a party to get to, skipped out, and did not give a shift report to the incoming staff person. She stated that Staff Whitney had asked the home nurse if Resident A's transport to the hospital was something that could wait. Ms. Prusi stated that PO's (physician orders) are something that is supposed to be documented, and information on the PO is supposed to be passed

during shift report, or documented in the communication log, and documented on the medication administration record.

On 01/05/2023, I emailed Resident A's public guardian inquiring if she had any concerns regarding Resident A's care. She responded on 01/10/2023 stated that she has no concern.

On 01/12/2023, I conducted an on-site inspection at the facility. I interviewed home manager Tabitha Johnson. She stated that Staff Whitney was told by nurse Linda Thomas, RN to take Resident A to St. Mary's, and that per Nurse Thomas, she was asked by Staff Whitney if it could wait until the next shift because she had a party to go to. Staff Johnson stated that originally Resident A went to the hospital in Standish, MI but was told to come back the next day because they did not have an ultrasound technician on staff at the time. Staff Johnson stated that Staff Whitney told staff Thelma Davis that Resident A had to go to the emergency room but did not clearly communicate anything to Staff Davis. She stated that Resident A needed a doppler or x-ray to check for blood clots because she could not feel her legs earlier that day, and she has a history of DVT. She stated that this incident occurred on 12/24/2022. She stated that Resident A did not experience anything health wise, but there was a high concern.

On 01/12/2023, during this on-site inspection I received copies of requested documents. Resident A's Ascension St. Mary's Hospital *ED Patient Discharge Summary* dated for 12/25/2022 was reviewed. It states that she was seen for *US Duplex Venous Lower Extremity Limited Unilateral*, *XR Foot AP + Lateral + Oblique*, and *XR Tibia Fibula (Lower Leg)*. She was admitted to the ER at St. Mary's in Saginaw at 13:58 (1:58 pm).

On 01/12/2023, I interviewed Resident A at the facility. She stated that she remembered going to the hospital last month but did not remember why. She stated that she can feel her legs now, but not before. Resident A appeared clean and appropriately dressed, sitting in the front living room of the home.

On 01/23/2023, I interviewed staff Harley Whitney via phone. Staff Whitney stated that she was talking on the phone with nurse Linda Thomas RN who was upset that Resident A could not get the doppler completed, so they discussed getting Resident A to another hospital. She stated that toward the end of her shift, she received a call asking her to stay longer due to a staff person calling in, and it triggered her anxiety. She stated that she asked another staff person to stay, and they agreed. She stated that when she spoke to the nurse over the phone, she was freaking out and said she had a party to go to. She stated that the nurse spoke with the other staff person via phone, so she left. She stated that she forgot to relay the information about Resident A to the manager, but that she also did not know what hospital Resident A was supposed to go to. She stated that she did communicate what she knew at the time to the next shift, and that she did not know Resident A had already gone to the hospital in Standish. She stated that she was not worried about the party, and it was

not her intention to put Resident A at risk. She stated that second shift ended up taking Resident A to the wrong hospital and that there was a concern because it delayed Resident A's care. She stated that she received disciplinary action and was suspended yesterday. She stated that Staff Thelma Davis came in on the next shift and she told Staff Davis Resident A had to go to the hospital per the nurse for a doppler. She stated that then Staff Davis took Resident A to the wrong hospital.

On 01/23/2023, and 01/26/2023 I made unsuccessful attempts to contact staff Thelma Davis.

On 01/23/2023, I interviewed Bay Arenac Behavioral Health nurse Linda Thomas, RN via phone. Ms. Thomas, RN stated that Resident A went to the emergency room initially on 12/25/2022. Resident A has a history of DVT and pulmonary embolism. Resident A could not feel her leg, so the on-call nurse instructed staff to take Resident A to the hospital out of precaution. At the hospital, they drew blood and asked Resident A to come back the following day for a doppler. Due to Resident A being high risk, she needed the doppler done that day, especially because Resident A had been on blood thinner and was in bed a lot. Nurse Thomas stated she confirmed they had a doppler at St. Mary's Hospital in Saginaw. She stated that a call was made to the facility instructing staff to take Resident A to Saginaw, but the message was not relayed, and staff took Resident A back to St. Mary's in Standish, MI. She stated that the delay in care was a mistake, but Resident A did get to the correct hospital. It was found that Resident A did not have a blood clot, and nothing happened to her, but she was admitted to the Saginaw hospital's ER for observation.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualification: **(b) Be capable of appropriately handling emergency situations.**
ANALYSIS:	I interviewed recipient rights investigator Melissa Prusi, home manager Tabitha Johnson, staff Harley Whitney, and nurse Linda Thomas, RN who all reported that there was a delay in Resident A getting needed medical attention due to staff Harley Whitney not appropriately communicating to the next shift staff that Resident A needed to be taken to the emergency room at St. Mary's hospital in Saginaw, MI. Staff took Resident A back to the hospital in Standish, MI which caused a delay in Resident A's medical treatment. There was a high concern due to her leg pain and numbness, as well as having a history of DVT and pulmonary embolism. There is a preponderance of evidence to substantiate a rule

	violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: On 01/01/2023, Staff Jenna Lachcik discovered Resident A was given medications that were previously on hold due to a medical procedure she was supposed to have done on 01/03/2023. Management failed to note the medication that were still supposed to be held on January's medication administration records. Due to the med sheets not being properly reconciled, Resident A was not able to have a medical procedure as scheduled.

INVESTIGATION: On 01/05/2023, I spoke with recipient rights investigator Melissa Prusi via phone. Ms. Prusi stated that according to notes for Resident A, medications were on hold as of 12/02/2022, and when Resident A started a new bubble pack (in January 2023), staff did not carry over the documentation to hold the new medication.

On 01/12/2023, I conducted an on-site inspection at the facility. I interviewed home manager Tabitha Johnson. She stated that aspirin and Eliquis (blood thinner), was supposed to be on hold for a procedure, but the medication was passed. She stated that Resident A ended up not getting the procedure anyway because she has been refusing to get out of bed or eat. She stated that the procedure is scheduled for next week (a colonoscopy). She stated that staff Joe Krystyniak passed the medications when they should have been on hold. She stated that Resident A's Oyster Shell and Vitamin D prescriptions were on hold for a different reason. She stated that she and assistant home manager Jenna Lachcik failed to note on the January 2023 medication administration sheet that the medications were on hold. She stated that she called the doctor's office to see if Resident A could still have the procedure, but the office did not call her back. She stated that she got ahold of the office the next day, and it sounded like she would still be able to have the procedure, but because Resident A was refusing prep, the doctor's office rescheduled.

On 01/12/2023, during this on-site inspection I received copies of Resident A's medication administration records (MARS) for December 2022 and January 2023. Per the December 2022 MARS, the hold on the Aspirin EC 325 mg (take one tablet by mouth) was held starting 12/29/2022. The Eliquis 5mg (take one tablet by mouth) was held starting 12/02/2022, and the Oyster Shell 500 Vit-D3 200 TB (take one tablet by mouth every 12 hours) was held starting 11/25/2022 per the MARS. Per the January 2023 MARS, the Oyster Shell was passed by Staff Krystyniak on 01/01/2023 at 7:00 am but was then held afterwards. However, staff Harley Whitney initialed the medication as passed again during the hold on 01/07/2023 at 8:00 pm. The aspirin was passed by Staff Krystyniak on 01/01/2023 at 7:00 am. And the Eliquis was passed on 01/01/2023 at 7:00 am by Staff Krystyniak.

On 01/12/2023, during this on-site, I also conducted the facility's renewal inspection. Medications were observed. No issues were noted.

On 01/12/2023, a copy of Resident A's *Professional Orders* (PO) were received and reviewed. On 11/25/2022 staff noted that Resident A's Oyster Shell prescription needed to be put on hold, and to resume on 12/25/2022, and a recheck of her calcium levels on 12/23/2022. On 12/02/2022, it states to hold her Eliquis 5 mg until follow up with primary care doctor. On 12/26/2022, the PO states to hold Resident A's aspirin due to a procedure on 01/03/2023. On 12/28/2022, there is a note to continue holding Eliquis 5 mg, and Oyster Shell until results from blood work are received. Bloodwork was scheduled 12/29/2022. On 01/04/2023, it notes again to hold the Oyster shell until further instructions from physician.

Resident A's Assessment Plan for AFC Residents dated 11/22/2022 notes for medication that "*staff will prepare and administer medications and treatments as ordered by physicians*." Documentation for a 01/03/2023 doctor's appointment with Resident A's Gastroenterology doctor states that Resident A had to hold on taking blood thinners, aspirin, etc. for five to seven days prior to the exam as they increase the risk of bleeding.

On 01/12/2023, I interviewed staff Jenna Lachcik who was present at the facility as well. She stated that the medications that were on hold were only passed one time, and it was the 7:00 am medications.

On 01/12/2023, I interviewed Resident A at the facility. She stated that she takes her medications with pudding. She stated that she has refused to go to an appointment lately but did not elaborate on what type of appointment it was.

On 01/05/2023, I emailed Resident A's public guardian inquiring if she had any concerns regarding Resident A's care. She responded on 01/10/2023 stated that she has no concern.

On 01/23/2023, I interviewed Bay Arenac Behavioral Health nurse Linda Thomas, RN via phone. She stated that medications are refilled at the first of the month, and with new med sheets they are supposed to document medications that are on hold and highlight them in yellow. She stated that Staff Johnson did the med list, and staff Lachcik checked it, but they did not document the holds. She stated that staff should have known, but the managers took responsibility for the mistake. She stated that the care was delayed, and Resident A also did not do the prep, but she did get the test done this past week and they are waiting for results to come in.

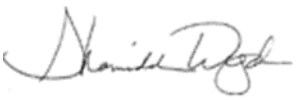
On 01/26/2023, I interviewed staff Joe Krystyniak via phone. He stated that he did pass Resident A's medications, he followed the five rights, and nothing was documented saying he needed to hold any medications. He stated that the home manager admitted that the holds needed to be documented. He stated that he was not sure what procedure Resident A needed that required the medications to be put on hold.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(a) Medications.**
ANALYSIS:	Recipient Rights investigator Melissa Prusi, staff Tabitha Johnson, Linda Thomas, RN, Staff Jenna Lachcik, and staff Joe Krystyniak were interviewed. They all reported that Resident A's medications that were on hold per a physician's order (Eliquis 5 mg, Aspirin EC 25 mg, and Oyster Shell 400 Vit D-3 200 TB) were passed to Resident A during the time period the medications were supposed to be on hold. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 01/27/2023, I conducted an exit conference with licensee designee Joe Pilot. I informed him of the findings and conclusions.

IV. RECOMMENDATION

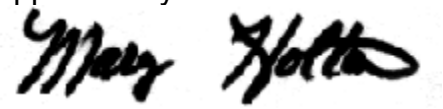
Contingent upon receipt of an acceptable corrective action plan, I recommend continuation of the AFC small group home license (capacity 6).



01/27/2023

Shamidah Wyden Date
Licensing Consultant

Approved By:



01/27/2023

Mary E. Holton Date
Area Manager