GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 30, 2023

Paula Barnes
Central State Community Services, Inc.
Suite 201
2603 W Wackerly Rd
Midland, MI 48640

RE: License #:	AS090010229
Investigation #:	2023A0123037
	Willow House

Dear Ms. Barnes:

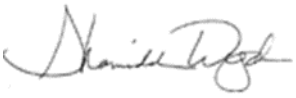
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AS090010229
Investigation #:	2023A0123037
Complaint Receipt Date:	04/18/2023
Investigation Initiation Date:	04/19/2023
Report Due Date:	06/17/2023
Licensee Name:	Central State Community Services, Inc.
Licensee Address:	Suite 201 2603 W Wackerly Rd Midland, MI 48640
Licensee Telephone #:	(989) 631-6691
Administrator:	Dale McAlpine
Licensee Designee:	Paula Barnes
Name of Facility:	Willow House
Facility Address:	400 North St Pinconning, MI 48650
Facility Telephone #:	(989) 879-2022
Original Issuance Date:	01/15/1991
License Status:	REGULAR
Effective Date:	11/06/2021
Expiration Date:	11/05/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 04/17/2023, Resident A was observed to have bruising of the left shoulder/left side of chest. He was unable to feed himself as usual. Staff reported that Resident A did not fall, and there were no incidents of being hit or targeted by another resident. Resident A is non-ambulatory and uses a wheelchair. He requires assistance with transfers and can pivot from wheelchair to surfaces and back. Resident A is non-verbal.	Yes

III. METHODOLOGY

04/18/2023	Special Investigation Intake 2023A0123037
04/19/2023	Special Investigation Initiated - Letter I sent an email to Melissa Prusi of recipient rights requesting a copy of the incident report.
04/19/2023	Contact - Document Received I received requested documentation via email.
04/19/2023	Contact - Telephone call made I spoke with BABHA nurse Tabbitha Heckman via phone.
04/19/2023	Contact - Telephone call received I received a voicemail from program coordinator Dale McAlpine via phone.
04/19/2023	Contact - Telephone call made I spoke with Mr. McAlpine via phone.
04/20/2023	Inspection Completed On-site I conducted an on-site at the facility. Staff interviews were conducted with recipient rights investigator Melissa Prusi.
04/28/2023	APS Referral APS referral completed.
05/15/2023	Contact- Telephone call made I spoke with Resident A's case manager via phone.

05/15/2023	Contact- Telephone call made I spoke Resident A's Guardian 1 via phone.
05/30/2023	Exit Conference I spoke with licensee designee Paula Barnes via phone.

ALLEGATION: On 04/17/2023, Resident A was observed to have bruising of the left shoulder/left side of chest. He was unable to feed himself as usual. Staff reported that Resident A did not fall, and there were no incidents of being hit or targeted by another resident. Resident A is non-ambulatory and uses a wheelchair. He requires assistance with transfers and can pivot from wheelchair to surfaces and back. Resident A is non-verbal.

INVESTIGATION: On 04/19/2023, I sent an email to recipient rights investigator Melissa Prusi, requesting a copy of the incident report. I received a copy of the incident report, and a statement from Ms. Prusi stating that Resident A utilizes a wheelchair, doesn't attempt to ambulate, and is totally dependent on staff for ambulation.

Ms. Prusi forwarded a copy of the incident report. The *AFC Licensing Division-Incident/Accident Report* states that on 04/16/2023, the assistant home manager Christina Matwyuk received a call from staff Denise Briggs who informed her that Resident A had a red area that appeared to be swelling up around 10:0pm while he was being toileted. Staff Briggs denied at the time that Resident A had fallen, been hit, dropped, or was in any kind of pain. It states that Resident A would be looked at for eczema on 04/17/2023 in the morning. The following morning on 04/17/2023, home manager Shawna Beaver arrived to work and noticed Resident A was not using his left hand correctly. Staff Nancy Syracuse at the time was assisting Resident A with feeding, and informed Staff Beaver that Staff Briggs and Staff Jessica Beckley informed her at shift change that Resident A started to bruise on his shoulder and would not eat for them. Staff Beaver asked Staff Michael Payne and Staff Syracuse to check Resident A over for injuries while they toilet him. They found bruising that was red and dark purple on his left front clavicle that was fading to a lighter bruise just above his nipple. The bruise was described as two to two and a half inches wide and about four to six inches long. Three written statements from Staff Matuyuk, Staff Briggs, and Staff Syracuse were included with the incident report.

On 04/19/2023, I made a call to Bay Arenac Behavior Health nurse Tabbitha Heckman via phone. Nurse Heckman stated that there is no way that staff does not know what happened to cause Resident A's injuries. She stated that she had Resident A sent to the hospital emergency room. The x-ray reports have not been received yet. Resident A's bruising is worse now than it was. Resident A's clavicle bone is broken, and pieces of bone are displaced. He has extensive bruising across his upper left back/shoulder, past his rib cage, and upper left arm. She stated that on

04/16/2023, several staff, including management left the home at 7:30 pm. At that time, Resident A was fine. At 10:30 pm, staff called the assistant home manager and reported that Resident A's chest was red and swollen. She stated that whatever happened took place between 7:30 pm and 10:30 pm that night. Nurse Heckman stated that on 04/17/2023, during the morning shift, staff called the manager about bruising. The home manager reported to the home and called her (Nurse Heckman), and the primary care doctor. She stated that Resident A is non-ambulatory, uses a wheelchair with a safety belt, and is non-verbal. She stated that Resident A was diagnosed with acute displaced comminuted fracture of the left clavicle with displacement of fragments. She stated that this injury was caused by force. Resident A has no osteoporosis diagnosis. She stated that it was extremely uncomfortable for Resident A to touch the area, and that all of the bruising is from whatever trauma happened to him, because his CBC (complete blood count) was fine.

On 04/19/2023, I received the photos of Resident A's bruising as well as copies of his MidMichigan Medical Center-Midland medical records from Nurse Heckman. The photos show extensive purple and yellow bruising on his left shoulder, chest, and arm. A Radiology Report dated 04/18/2023 states that Resident A had an acute displaced and comminuted left midclavicular fracture deformity with no other fracture or dislocation.

On 04/19/2023, I received a voicemail from Central State Community Services program coordinator Dale McAlpine. He stated that staff noticed a red mark on Sunday (04/16/2023). On 04/17/2023, staff spoke with Nurse Heckman who recommended x-rays. The x-rays were inconclusive, and staff brought him back to the facility. The next day, Resident A's shoulder had a large bruise that spread to his upper left chest. The nurse came out to look at him and requested x-rays again. A fractured clavicle was found, and they do not know how the injury occurred.

On 04/19/2023, I spoke with Mr. McAlpine via phone. He stated that they are getting differing stories from staff, and staff are pointing fingers at one another. He stated that the injury started as a red mark. Then next shift checked him, and there were no changes, but within 24 hours it turned into a bruise. Resident A was taken to the hospital in Standish, MI and the hospital sent him home. He stated that the assumption is that Resident A fell, as he does not walk. One staff heard another staff tell Resident A "help me stand you up" while in the bathroom at about 3:00 am on 04/17/2023. He stated that Staff Briggs stated that Staff Beckley was toileting Resident A, and Staff Beckley stated that Staff Briggs was toileting Resident A.

On 04/20/2023, I conducted an on-site with recipient rights investigator Melissa Prusi to conduct staff interviews. The interviews are as follows:

Home manager Shawna Beaver was interviewed. She stated that she spoke with both staff. Staff Beckley's story has not changed, but Staff Briggs' story and timeline is all over the place. Staff Briggs is a 19-year employee who knows all protocols and what to report. Staff Beckley just started working on 03/28/2023. She stated that

she thinks both staff toileted Resident A before bed. She stated that she is not sure which staff got Resident A off the toilet, but that one of the staff must have dropped Resident A or he fell in the bathroom while staff were helping him with toileting. Resident A is non-verbal. She stated that he either hit the toilet rack or fell on the toilet. She stated that Resident A uses a shower chair with a belt over the toilet, and he also uses a gait belt. She stated that Resident A could have fell off the shower chair if he was not buckled, or the shower chair could have tipped forward. She stated that Staff Briggs may have some personal issues going on. Staff Beaver stated that she was in the home at 7:30 pm on 04/16/2023, and Resident A did not have any bruising at that time. She stated that whatever happened, it was an accident.

Assistant home manager Christina Matuyuk was interviewed. She stated that she worked on 04/16/2023 from 7:00 am to 7:00 pm with staff Michael Payne. She stated that Staff Beaver arrived at the home at about 5:30 pm regarding a previous incident about Staff Briggs not following protocol. She stated that her shift with Staff Payne went fine, and there were no issues with Resident A. She stated that at 10:22 pm, she got a call from Staff Briggs that Resident A was red and swollen. She stated that she asked Staff Briggs questions, and Staff Briggs denied that Resident A fell. She stated that she told Staff Briggs she would call Staff Beaver. Staff Beaver reported that staff needed to monitor Resident A and she would check him in the morning. Staff Matuyuk stated that she called Staff Briggs back, and told her what Staff Beaver said, and to give management a call if there were any changes. She stated that the bruising was discovered by staff the next morning. She stated that if Staff Payne had noticed something, he would have said something. She stated that Resident A had no signs of distress during their shift and was using his arm and hand. Staff Matuyuk stated she took residents on an outing earlier that day (on 04/16/2023), and when she came back, she was going to take Resident A on an outing but didn't because it was pouring raining.

Staff Jessica Beckley was interviewed. She stated that she worked on 04/16/2023 from 7:00 pm through 04/17/2023 at 7:00 am. She stated that Staff Beaver, Staff Matuyuk, and Staff Payne were present at the start of her shift, and there were no major issues noted at that time. She stated that Resident A was in his recliner at the start of shift. She stated that she was assigned to Resident A, but Staff Briggs assisted her with Resident A. She stated that at 8:00 pm, she gave Resident A a snack. At about 8:30 pm, Staff Briggs assisted her with Resident A with getting off the toilet. Resident A then went to his room to watch television, and he seemed fine. At the next toileting, she (Staff Beckley) was assisting another resident, so at about 9:40 pm, Staff Briggs toileted Resident A. She stated that she observed redness on Resident A at about 10:15 pm, and Resident A was struggling to use his left arm when laying down. She stated that his shirt came down a little, and that is when she noticed the redness. She stated that she told Staff Briggs that they needed to contact the home manager or assistant home manager. She stated that at 10:22 pm, Staff Briggs finally made the phone call, and that it was Staff Briggs' responsibility to do so because she was the med passer. She stated that she had to convince Staff

Briggs to make the call and it took her seven minutes to convince her. She stated that she never heard any commotion from the bathroom, and no sounds of pain coming from Resident A. Staff Beckley stated that Staff Matuyuk called back and had asked if there was any bruising, but there was only redness at the time. She stated that she was told later that Staff Beaver was going to come and check Resident A out. Staff Beckley stated that in the morning, Resident A had visible bruising, and that staff thought it was maybe eczema or his psoriasis, but she personally thought it was bruising. She stated that she later got a call from Staff Beaver asking what happened. She stated that between 10:15pm and 10:22 pm on 4/16/2023, she had to read the nursing guidelines to Staff Briggs. She stated that she was not the only staff person toileting Resident A that night, and she denied witnessing Resident A fall.

Staff Michael Payne was interviewed. Staff Payne stated that he worked from 7:00 am to 7:00 pm on 04/16/2023. He stated that he provided personal care to Resident A and got Resident A ready for bed. He denied seeing any marks or bruises on Resident A at that time. He stated that he worked his shift with assistant home manager Christina Matuyuk. He stated that nothing on his shift appeared unusual, and Resident A was not favoring one arm over the other, and he had no falls during their shift. He stated that if something had happened, he would have yelled out for assistance and written an incident report. He stated that Staff Briggs and Staff Beckley worked the next shift after him, and that Resident A was in his recliner a little after 7:00 pm when he left work.

Staff Denise Briggs was interviewed. Initially she stated that she worked 3:00 pm to 11:00 pm on 04/16/2023, and it was towards the end of the day is when Resident A was “red” and that is when she called management. She then stated that she worked from 7:00 pm to 7:00 am with staff Jessica Beckley. She stated that staff Christina Matuyuk told her they had an outing earlier that day. Later in the interview she stated that she was flabbergasted he was hurt and said “*they were on an outing. Did I hurt him? No*.” (Implying he was injured during an outing.) Staff Briggs stated that Resident A was in his recliner chair at the start of the shift, wearing his pajamas, and had already had his evening personal care completed. She stated that at 8:00 pm snack, Resident A was using his hands, and there were no issues. She stated that Staff Beckley toileted Resident A. She stated that at around 10:00 pm, she heard Staff Beckley say, “stand up.” She stated that she went in the bathroom to see what was going on. She stated that once in there, she pushed Resident A’s wheelchair closer to the toilet, he grabbed the grab bar with both hands and transferred to the wheelchair. She stated that Resident A was toileted before that at snack time as well by Staff Beckley. She then stated that they saw redness, and she does not know why they waited until 10:00 pm to call management. Staff Briggs then stated that she wrote two witness statements about what happened because Staff Beaver told her to re-write her statement. When asked what really happened to Resident A, Staff Briggs stated that “they were busy.” Staff Briggs admitted during the interview that she failed to follow the nursing guidelines and did not call the nurse. She stated that she called the assistant home manager. She also stated that

she saw Resident A's veins and the beginning of the bruising (which contradicts only seeing a red mark).

During Staff Briggs' interview, we brought in Staff Beaver. Per Staff Beaver, she denied that she had Staff Briggs write two witness statements. We then asked for Staff Matuyuk to come into the room. Staff Matuyuk was asked if Staff Beaver ever questioned Staff Briggs about her written statement. Staff Matuyuk stated that Staff Beaver questioned the time frame of staff noticing the redness of Resident A, who toileted him, and which staff person was providing the care. Staff Briggs had stated that the redness was observed at 7:30 pm. Per Staff Beaver and Staff Matuyuk, Staff Briggs altered the skin audit documentation after it was initially completed.

On 04/20/2023, Resident A was observed sitting in his wheelchair in his bedroom watching television. He appeared clean and appropriately dressed, wearing a sling on his left arm. I observed some of the extensive bruising around his shoulder and torso. It appeared visibly yellow and purple. The other residents present in the home were observed as well and appeared to be clean and appropriately dressed.

On 04/20/2023, I received copies of the incident reports from the facility. An incident report dated for 04/18/2023 was received in addition to the incident report dated 04/16/2023-04/17/2023. The *AFC Licensing Division- Incident/Accident Report* dated 04/18/2023 states that Nurse Heckman instructed staff to take Resident A to the Michigan Health Park in Bay City because he had been to the hospital in Standish, MI the day before but the x-ray results taken on 04/17/2023 were not available. During this hospital visit, Resident A was diagnosed with a broken clavicle and was provided with a sling and was instructed to follow up with an ortho doctor in a few days.

A copy of Resident A's *Assessment Plan for AFC* Resident's completed on 01/02/2023 states that Resident A needs assistance with toileting, as well as all other personal care needs. Resident A uses a wheelchair and needs assistance getting into bed and other chairs. The assistive devices he uses are noted to be a wheelchair, bed rails, shower chair, toilet chair, gait belt, and handicap rail. The gait belt is used for transferring. A copy of his *Health Care Appraisal* dated 03/21/2023 states that Resident A is wheelchair bound. A copy of Resident A's Bay Arenac Behavioral Health *Plan of Service* dated 01/17/2023 was reviewed. It states that Resident A has a gait belt that he uses at all times so staff can assist him safely during transferring. Resident A is a fall risk and utilizes a wheelchair to reduce his risk of falls.

On 05/15/2023, I spoke with Resident A's Guardian 1 via phone. Guardian 1 stated that they have not heard of anything other than Resident A having a fractured collar bone. Guardian 1 stated that Resident A has lived at Willow House for 15 years, and that whatever happened was an accident. Guardian 1 stated that he was told that Resident A was in the bathroom and fell. He stated that he does not think it was intentional abuse, but Resident A was probably left alone and should not have been.

On 05/15/2023, I spoke with Resident A's Bay Arenac Behavioral Health case manager Brianna Cook via phone. She stated that she received an incident report regarding the situation and spoke with the home manager. She stated that staff were not sure exactly what happened, but it sounds like the incident occurred while toileting Resident A. She denied having any concerns regarding Resident A's care prior to the incident, or currently. She stated that the facility responded appropriately.

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:	Nurse Heckman stated that on 04/16/2023, at 10:30 pm, staff reported to management that Resident A's chest appeared to be red and swollen. She stated that Resident A was diagnosed acute displaced comminuted fracture of the left clavicle with displacement of fragments. She stated that this injury was caused by force, and there is no way staff on shift at the time did not know what happened to Resident A. On 04/19/2023, I received the photos of Resident A's bruising as well as copies of his MidMichigan Medical Center-Midland medical records. The photos show extensive purple and yellow bruising on his left shoulder, chest, and arm. A Radiology Report dated 04/18/2023 states that Resident A had an acute displaced and comminuted left midclavicular fracture deformity with no other fracture or dislocation. Staff Jessica Beckley was interviewed and reported seeing redness on Resident A at about 10:15 pm on 04/16/2023 (after Staff Denise Briggs toileted Resident A), and the next morning he had visible bruising. She denied witnessing Resident A fall. Staff Denise Briggs admitted during the interview that she failed to follow the nursing guidelines and did not call the nurse. She stated that she called the assistant home manager. She also stated that she saw Resident A's veins and the beginning of the bruising (which contradicts only seeing a red mark) on 04/16/2023.

	An incident report dated 04/18/2023, states that Resident A went for x-rays on 4/18/2023 and 4/17/2023. Guardian 1 was interviewed and stated that he thinks Resident A may have fell and does not think the injuries are the result of intentional abuse. Resident A's case manager Brianna Cook denied having any concerns, and state that the facility responded appropriately. There is a preponderance of evidence to substantiate a rule violation in regard to protection and safety being attended to at all times. Resident A sustained an injury that per Nurse Heckman had to have been caused by force. Staff denied knowing how the injury occurred.
CONCLUSION:	**VIOLATION ESTABLISHED**

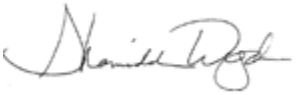
APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Nurse Heckman stated that on 04/16/2023, at 10:30 pm, staff reported to management that Resident A's chest appeared to be red and swollen. A Radiology Report dated 04/18/2023 states that Resident A had an acute displaced and comminuted left midclavicular fracture deformity with no other fracture or dislocation. Staff Jessica Beckley was interviewed and reported seeing redness on Resident A at about 10:15 pm on 04/16/2023 (after Staff Denise Briggs toileted Resident A), and the next morning he had visible bruising. Staff Denise Briggs admitted during the interview that she failed to follow the nursing guidelines and did not call the nurse. She stated that she called the assistant home manager. She also stated that she saw Resident A's veins and the beginning of the bruising (which contradicts only seeing a red mark) on 04/16/2023. There is a preponderance of evidence to substantiate a rule

	violation in regard to seeking needed care immediately in case of an accident or sudden adverse change in Resident A's physical condition. Resident A sustained a broken clavicle. Staff were not forthcoming with what they reported about what happened to Resident A to management, and Staff Briggs failed to follow protocol by calling the nurse. Resident A did not receive any medical attention until the following day on 04/17/2023 but had to go to another hospital on 04/18/2023 before being diagnosed with a broken clavicle.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 05/30/2023, I conducted an exit conference with licensee designee Paula Barnes via phone. I informed her of the findings and conclusions.

IV. RECOMMENDATION

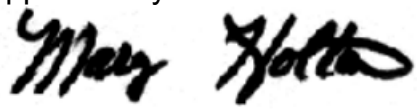
Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC small group home license (capacity 1-6).



05/30/2023

Shamidah Wyden Date
Licensing Consultant

Approved By:



05/30/2023

Mary E. Holton Date
Area Manager