GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 21, 2023

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

RE: License #: AS230396556
Investigation #: 2023A0581037
Grand Ledge

Dear Ms. Barnes:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the quality of care 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,

Cathy Cushman

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS230396556
Investigation #:	2023A0581037
Complaint Receipt Date:	05/23/2023
Investigation Initiation Date:	05/24/2023
Report Due Date:	07/22/2023
Licensee Name:	Central State Community Services, Inc.
Licensee Address:	Suite 201 2603 W Wackerly Rd Midland, MI 48640
Licensee Telephone #:	(989) 631-6691
Administrator:	Dana Marshall
Licensee Designee:	Paula Barnes
Name of Facility:	Grand Ledge
Facility Address:	803 W. Main Street Grand Ledge, MI 48837
Facility Telephone #:	(517) 627-4604
Original Issuance Date:	01/29/2019
License Status:	REGULAR
Effective Date:	07/29/2021
Expiration Date:	07/28/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATIONS

	Violation Established?
Resident A was not supervised by direct care workers after she was secured into her wheelchair.	Yes
Resident A was restrained in her wheelchair by direct care workers.	Yes
Additional findings.	Yes

III. METHODOLOGY

05/23/2023	Special Investigation Intake 2023A0581037
05/24/2023	APS Referral made via email
05/24/2023	Special Investigation Initiated - Letter Made an APS referral
05/24/2023	Contact - Telephone call made Interview with Resident A's supports coordinator, Lauren Spencer
05/24/2023	Contact - Telephone call made Interview with Recipient Rights Officer, Greg Fox.
05/24/2023	Referral - Recipient Rights Eaten, Clinton and Ingham Co. RRO received the allegations and are investigating. No referral necessary.
05/24/2023	Contact - Telephone call received Interview with APS specialist, Shelly Stratz. APS accepted the complaint for investigation.
05/24/2023	Contact - Document Sent Email to Ms. Stratz
05/24/2023	Contact - Document Sent Email to Mr. Fox, RRO
05/24/2023	Contact - Document Received Email from Ms. Spencer
05/31/2023	Contact - Telephone call received

	Interview with Ms. Stratz.
05/31/2023	Contact - Document Received Email from Ms. Stratz
06/01/2023	Inspection Completed On-site Interview with direct care workers and Administrator.
06/05/2023	Contact - Telephone call made Interview with Detective Kirk DeWitt
06/05/2023	Contact - Document Received Email from Administrator, Dana Marshall, containing Resident A documentation.
06/06/2023	Contact – Document Received Email from Ms. Spencer.
06/08/2023	Contact - Document Sent Email to Detective DeWitt
06/08/2023	Contact - Telephone call made Interview with Detective DeWitt
06/09/2023	Contact - Telephone call made Interview with Ms. Spencer
06/12/2023	Contact - Document Sent Email to Detective DeWitt
06/12/2023	Contact - Telephone call made Interview with Detective DeWitt
06/28/2023	Inspection Completed-BCAL Sub. Non-Compliance
06/30/2023	Contact – Telephone call made Interview with Victoria Thomas, CEIC CMH Community Services for Developmentally Disabled Residential Coordinator.
06/30/2023	Contact – Telephone call made Interview with Dana Marshall, Administrator. Requested training information.
07/06/2023	Contact – Document Sent Email to Detective DeWitt.

07/06/2023	Contact – Document Sent Email to Ms. Marshall.
07/06/2023	Referral – Attorney General Confirmed with Detective DeWitt via email the AG's office was assigned to the case.
07/06/2023	Contact – Document Received Email from Ms. Marshall.
07/06/2023	Contact – Document Sent Email to AG investigator, Mark Lewandowsky.
07/06/2023	Contact – Telephone call received Interview with Mr. Lewandowsky
07/11/2023	Contact – Document Sent Email correspondence with Detective DeWitt.
07/12/2023	Contact – Telephone call made Interview with DCW Ms. A. Dockery.
07/12/2023	Contact – Telephone call made Left voicemail with DCW Ms. D. Dockery.
07/12/2023	Contact – Telephone call made Interview with Guardian A1.
07/17/2023	Contact – Document Sent Email correspondence with CEI CMH speech and language pathologist, Darcy Whitney.
07/18/2023	Exit conference with Licensee Designee, Paula Barnes.

ALLEGATION:

Resident A left unsupervised by direct care workers after she was secured into her wheelchair.

INVESTIGATION:

On 05/23/2023, I reviewed an *AFC Licensing Division - Incident / Accident Report* (IR), dated 05/23/2023, which was completed by direct care worker (DCW), Alex Dockery, but also signed by the facility's Administrator, Dana Marshall. In addition to the IR, Ms. A. Dockery also submitted a signed statement. According to Ms. A.

Dockery's signed written statement, on 05/22/2023, she placed Resident A in her wheelchair "due to her having just ate and plus she was very unsteady on her feet." Ms. A. Dockery documented it was in Resident A's treatment plan to "sit in an upright position for 30 mins to an hour after eating to help with her GERD." Ms. A. Dockery documented Resident A goes in her wheelchair to prevent her from laying down after eating. Ms. A. Dockery documented Resident A was "sitting in her wheelchair with her seatbelt on." She also documented after she got Resident A in her wheelchair, she took Resident B to his room for a "brief change" while another direct care worker took Resident C to her room for a brief change, as well. Ms. A. Dockery documented after she completed Resident B's brief change, she went into the living room and discovered Resident A "as if she was trying to get out of her wheelchair by sliding under her seatbelt." Ms. A. Dockery documented observing the seatbelt "was stuck on her neck and staff had to cut the seatbelt to get it off of her." Ms. A. Dockery did not identify in the IR the name of the specific staff who cut the seatbelt. Ms. A. Dockery documented Resident A was not breathing and she immediately began chest compressions, which were done until emergency medical technicians (EMTs) arrived. She documented EMTs were able to revive Resident A, got a pulse and rushed her to a local hospital where she was admitted. According to the IR, the corrective measure to prevent recurrence was indicated as "going to request meeting to modify wheelchair to have a chest harness instead of just a seatbelt."

On 05/24/2023, I interviewed Resident A's Clinton, Eaton, and Ingham County Community Mental Health (CEI CMH) supports coordinator, Lauren Spencer, via telephone. Ms. Spencer stated Resident A resided in the facility since 2011. She stated facility staff had purchased Resident A a "transport wheelchair" to assist with getting her into her doctor appointments. She stated there was an order for the wheelchair that was written by Resident A's physician. Ms. Spencer stated Resident A had only one wheelchair, rather than having multiple types of wheelchairs.

Ms. Spencer also stated in approximately January or February 2023, Resident A had a swallow study completed and it was determined she was "silently aspirating"; therefore, Resident A was switched to a pureed and thickened liquid diet. She stated it was recommended Resident A sit upright for at least 30 minutes to prevent Gastroesophageal Reflux Disease (GERD). Ms. Spencer stated DCWs were utilizing Resident A's wheelchair to sit her upright because it had been explained to her by DCWs and Ms. Marshall that if Resident A was put into her recliner or a "more comfortable chair" then she would "have a tendency to lay down", which would cause issues if she experienced symptoms relating to GERD. Ms. Spencer stated she did not believe Resident A had the cognitive ability or the dexterity of her fingers to undo a seatbelt despite having the ability to move her hands. She stated Resident A was also non-verbal. Ms. Spencer stated there was no specific written supervision requirement of Resident A after eating like DCWs needing to keep their eyes on her or to provide any type of one-to-one supervision.

On 05/24/2023, I completed an internet search for both aspiration and silent aspiration. According to www.webmd.com, aspiration is “when something you swallow "goes down the wrong way" and enters your airway or lungs”. It was noted that people who have a hard time swallowing, which is defined as dysphagia, are more likely to aspirate. It was also noted that older adults, those who have suffered a stroke or individuals who have a developmental disability may aspirate more often or have problems with swallowing.

On www.clevelandclinic.org, “silent aspiration” was explained similarly to aspiration whereas someone may accidentally inhale food, liquid or other material into their trachea (windpipe or airway) and not know it; however, with silent aspiration, you may not cough or feel anything. Additionally, it was further explained that with silent aspiration, you probably don’t know that it’s happening or even how often it is happening. It was indicated that when aspirating liquids regularly a person can develop aspiration pneumonia or an infection in your lungs, which can be serious.

On 05/24/2023, Ms. Spencer stated she did not know how Resident A’s current medical status at this time. She stated she reviewed medical documentation, which indicated Resident A was without oxygen for approximately 20-30 minutes and suffered cardiac arrest; however, medical personnel were unable to determine at what point she suffered cardiac arrest. Ms. Spencer stated Resident A was currently on a ventilator.

Ms. Spencer stated all the residents in the facility require “a high level of personal care” and have medical needs. She stated there were three other CEI-CMH residents admitted to the home, who were all non-verbal, as well. Ms. Spencer also stated Resident A was “severely underweight” weighing only approximately 80 pounds; however, she stated this was being addressed medically.

Ms. Spencer also emailed me Resident A’s CEI CMH annual assessment, dated 04/28/2023, her *CEI CMH Treatment Plan Annual / Initial*, dated 05/04/2023, her *CEI CMH Speech Evaluation*, dated 05/11/2023, her *CEI CMH Speech and Language – Dysphagia Care Plan*, dated 05/2023, and the prescription for the wheelchair.

According to my review of the CEI CMH assessment plan, there was no indication of the level of Resident A’s supervision within the home; however, it was determined Resident A could be in the front or back yard of the facility independently; however, staff should monitor Resident A every 15 minutes. The assessment stated Resident A is “ambulatory and able to maneuver around her home and in and out of bed on her own." It stated she can get out of “resting situations” and “often spends most of her time pacing and walking back and forth between her room, common areas, and outside.” It also stated, “Household chores she requires hand over hand assistance for, but works on improving independence through goals in her treatment plan. [Resident A] assisting with tasks is also difficult at times due to unsteady gait caused by low weight.”

Upon my review of Resident A's *Treatment Plan*, it contained similar information to Resident A's assessment plan; however, it identified Resident A's specific goals, and interventions, as well as the strengths and barriers to reach these goals.

Resident A's Speech Evaluation included the following:

> "She has resided at the Grand Ledge AFC since approximately 2011. [Resident A] is ambulatory; however, staff report that she has been falling lately. This was especially noted when going to Dr. appointments. They have requested a wheelchair for use on outings of any distance. [Resident A] is nonverbal. She uses multi-modal communication to express a few wants and needs. In addition, others are required to interpret her communicative intent behaviors. [Resident A] receives Case Management, Nutrition Services and Speech Services through CMHA-CEI. She has a new home manager, Alex."

Also included in the Speech Evaluation was the following:

> "Staff feed [Resident A] her meals. They have found that her regurgitation is less if they give her food separate from her fluids. Fluids are often provided approximately an hour after receiving her food. [Resident A] continues to display difficulty maintaining her weight. However, she eats all of her meals along with Boost supplements. Staff take [Resident A's] temperature 1-2 hours after meals to monitor for silent aspiration. [Resident A] has not had any instances of low grade fevers indicative of silent aspiration.
>
> Staff are aware that [Resident A] should remain upright for at least 30 minutes after eating. However, [Resident A] often goes to her recliner and curls up in a ball on her side. She does not want to be moved and if staff readjust her, once staff leave she returns to curling up in a ball. Speech services will continue until [Resident A's] follow up appointment with her GI Specialist. Speech Services may change depending upon the recommendations."

Based on Resident A's *Speech and Language – Dysphagia Care Plan*, she was diagnosed with "moderate-severe oropharyngeal dysphagia" and her recommended means of nutrition was a pureed diet and mildly thick (nectar) liquid consistency. Resident A's "Supervision and Eating Procedures" were directed as the following:

- “Environment should be calm and free from distractions.
- Inform [Resident A] as to the contents of her meal.
- Ensure that her food is the appropriate texture – Puree.
- Liquids should be mildly thick –nectar.
- [Resident A] should take small bites and eat slowly.
- Staff should watch for a swallow with both solids and liquids and cue with a dry spoon (bring dry spoon to her mouth) to trigger a swallow reflex. This should be done with both food and drink.
- [Resident A] should remain upright for 30 minutes after eating.
- **Temperature check: Take temperature 1-2 hours after eating. If [Resident A] has a low grade temperature of 100-101 take her to her Dr. or urgent care.”

There were no orders or written directions in Resident A’s *Speech and Language – Dysphagia Care Plan* for Resident A to be buckled into her transport wheelchair for any length of time before, during or after eating based on my review.

I reviewed the prescription for Resident A’s wheelchair, dated 09/26/2022, which included Resident A’s name, the date, the physician’s signature, her date of birth, her diagnosis of “autism” and “intellectual disability”, and the order of “transport wheelchair with seatbelt PRN”. There was no additional information included in the prescription including no order from the physician to use the wheelchair with seatbelt to assist Resident A with remaining upright after eating.

At the time of this medical injury, Resident A was 58 year old and diagnosed with Autism, GERD, profound intellectual disability, dysphagia, unspecified mood disorder, dysthymic disorder, and seizures per my review of her resident record. My review of the record also noted Resident A was ambulatory most of the time despite being in a wheelchair at the time of this allegation.

On 05/24/2023, I coordinated with CEI CMH Recipient Rights Officer (RRO), Greg Fox, and Adult Protective Services (APS) specialist, Shelly Stratz, to conduct interviews on 06/01/2023 at the facility with the DCWs who were present when the incident occurred with Resident A.

On 05/30/2023, Ms. Spencer emailed me stating Resident A passed away on 5/29/2023. She stated she would forward Resident A’s death certificate when she received it.

On 06/01/2023, I conducted an inspection at the facility with conjunction with Mr. Fox, Ms. Stratz, and Grand Ledge police department detective, Kirk DeWitt. Also present during the inspection was the facility’s Administrator, Dana Marshall.

We interviewed DCW, Deborah Dockery, regarding the incident that occurred with Resident A on 05/22/2023. Ms. D. Dockery stated she came into the facility around 10 am to provide supervision to residents while Ms. A. Dockery transported Resident A to a medical appointment, which she believed to be at approximately 11:45 am.

Ms. D. Dockery stated Resident A had already eaten as she was in her wheelchair sitting upright. She stated Resident A needed to sit upright in her wheelchair for approximately 30 minutes to one hour due to GERD symptoms of aspiration and reflux. Ms. D. Dockery indicated Resident A would sit in both a regular chair and her wheelchair while she was being fed. Ms. D. Dockery stated due to Resident A's reflux, she was on a pureed and/or thickened liquid diet.

Ms. D. Dockery stated Resident A was ambulatory without the wheelchair but was known to be unsteady on her feet or "off balance." She stated Resident A would require the use of the wheelchair "if she was falling a lot" to prevent her from getting injured. She stated the seatbelt was used to keep Resident A secure and upright as she indicated Resident A would otherwise "curl into a ball." She stated Resident A would assume this type of position if she were in her recliner, which is why the seatbelt was used while Resident A was in the wheelchair.

Ms. D. Dockery stated she had no idea where the wheelchair came from, but knew it was only for Resident A and not any of the other residents. She stated Resident A was unable to undo the seatbelt. She stated that while Resident A could grab things with her hands such as door handles, she would not have been able to use her fingers and hands to unclasp the seatbelt. She indicated a DCW would have to complete this task for Resident A.

Ms. D. Dockery stated she was unable to recall the time in which Resident B and Resident C required assistance with incontinence brief changes but stated both she and Ms. A. Dockery had to change them at the same time. She stated the residents utilize Hoyer lifts; therefore, it took Ms. D. Dockery "a bit longer" to get Resident C's brief changed. She stated she did not know how long it took her to change Resident C and stated she "didn't want to guess." Ms. D. Dockery stated Resident A and the other residents are all non-verbal so she would not have known if Resident A needed assistance while she was in Resident C's bedroom.

Ms. D. Dockery stated Ms. A. Dockery yelled for help after she returned to the living room with Resident B. Ms. D. Dockery stated Ms. A. Dockery tried unclasping the seatbelt on Resident A's wheelchair, but it would not unlock. Ms. D. Dockery stated she (Ms. D. Dockery) had to cut the seatbelt to get it off Resident A's neck area. She stated she contacted 911 and EMS arrived shortly after.

We interviewed Ms. A. Dockery, as well. She stated she'd been working in the facility since approximately February 2023. She stated on the day of the incident with Resident A, she had arrived to work at 7 am. She stated she got residents up for the day, administered medications, showered the residents, and fed them breakfast, which was approximately between 8 am and 8:30 am. She stated Resident A's routine is a "little different" as she is fed "every couple of hours." She stated while Resident A is being fed, she does not need to be secured with a seatbelt in any type of chair, including the wheelchair. Ms. A. Dockery stated Resident A's food has to be pureed and liquids have to be thickened due to Resident

A's history of regurgitation. Ms. A. Dockery stated after Resident A was fed between 8 am and 8:30 am she was put into her wheelchair and secured with the seatbelt for approximately 30 minutes to one hour. She stated Resident A did have reflux after eating that morning; however, this was normal for her. Ms. A. Dockery stated she was not aware or told Resident A needed additional monitoring or supervision after showing signs of reflux or while being secured in her wheelchair.

Ms. A. Dockery stated after Resident A ate breakfast she was put in her wheelchair. She stated after the required time of sitting upright, she got Resident A out of the wheelchair. She stated she observed Resident A walking around, and then observed Resident A fall and hit her head on the fireplace hearth. She stated there was foam on the hard edges of the fireplace and that Resident A did not sustain any injuries from the fall as she looked her over and she had no marks or bruises. Ms. A. Dockery was unable to recall how long Resident A was walking around the facility before she ate again at approximately 10 am. Ms. A. Dockery stated Resident A was given applesauce at 10 am. She stated after feeding Resident A, she secured her in the wheelchair with the seatbelt in an upright position. Ms. A. Dockery stated she fed Resident A both times at the dining room table. She stated it was common practice to feed Resident A at the table, to put her in the wheelchair for the required amount of time, and then allow Resident A to move to her recliner or walk around.

She stated after she fed Resident A her applesauce snack and had her sitting upright, she took Resident B to his room for an incontinence brief change. She stated Ms. D. Dockery also took Resident C back to her room for an incontinence brief change at that time, as well. Ms. A. Dockery stated she did not believe she left Resident A unsupervised for longer than 15 minutes. She stated she thought Resident A's medical appointment was for 11:30 am and she was trying to leave at approximately 11 am to get there on time. She stated while she was changing Resident B's incontinence briefs, she discovered he had "a huge blowout", which required more involvement than just changing his brief as she also had to change his pants. She stated when she brought Resident B back in the living room, she observed Resident A slumped down in her wheelchair. Ms. A. Dockery stated she was unable to get the seatbelt button to unclasp or come apart. She stated she believed there was too much pressure on the lock from Resident A sliding down into the chair, which did not allow the lock to release. She stated she called for Ms. D. Dockery to come assist her; however, Ms. D. Dockery was also unable to unclasp the belt so she cut the seatbelt. She stated the seatbelt was near Resident A's neck. She stated she had not experienced any prior issues with the seatbelt (e.g., not unclasping, jamming, etc.) prior to this incident. Ms. A. Dockery stated she completed chest compressions until EMTs arrived.

DCW A. Dockery stated while Resident A was in her wheelchair, she acknowledged cinching the seatbelt to tighten it so that Resident A was upright. She also stated Resident A was non-verbal so Resident A would not have been able to tell her or she would not have known when Resident A wanted out of the wheelchair. She also confirmed Resident A would not have been able to undo the seatbelt by herself

without the assistance from DCWs. Ms. A. Dockery stated she would undo Resident A's seatbelt when she deemed Resident A had been in it upright for the required length of time. Ms. A. Dockery stated she never saw Resident A try to get out of the seatbelt or wheelchair while she was secured in the wheelchair. She stated she observed Resident A "scoot" down in the wheelchair on occasion; however, she stated this behavior was rare. She denied Resident A scooting so low in the wheelchair that it was a concern to her. Ms. A. Dockery stated Resident A was still upright even if she scooted down in her wheelchair.

Ms. A. Dockery stated a physician's prescription was obtained for the transport wheelchair. She stated Resident A was assessed by a speech therapist and it was determined Resident A needed to sit upright for 30 minutes to an hour after eating, otherwise, Resident A would silently aspirate. She stated this order was received in approximately February 2023. Ms. A. Dockery stated she had not observed Resident A aspirate and would not know what it looked like when she was experiencing it due to it being "silent."

We interviewed the facility's Administrator, Dana Marshall, as well. Ms. Marshall stated she purchased Resident A's wheelchair off Amazon. She stated the wheelchair was being utilized due to Resident A, at times, being unstable on her feet and because of her GERD symptoms. Ms. Marshall stated she had not observed Resident A struggle with aspiration either; however, it was common for Resident A to have reflux. Ms. Marshall stated the seatbelt came with the wheelchair and stated nothing was added to or taken off the wheelchair at the time Resident A was utilizing it.

Ms. Marshall stated Resident A was placed in the wheelchair when she was exhibiting symptoms of being unsteady. She stated Resident A's seatbelt was used for safety reasons, but indicated the seatbelt was not always used when Resident A was in her wheelchair.

During the inspection, I reviewed Resident A's "*Food and Fluid Intake*" log for 05/22/2023. According to this log, Resident A ate breakfast at 8 am and experienced reflux at 8:30 am in the amount of 1 cup. Resident A was then fed approximately 1 cup of applesauce and 8 oz of water at 10 am. The log indicated Resident A again experienced reflux at 10:15 am in the amount of 1 cup.

On 06/05/2023, Ms. Marshall sent via email copies of Resident A's AFC documents including her *Assessment Plan for AFC Residents* (assessment plan), dated 01/01/2023 and Resident A's *Food and Fluid Intake log* for May 2023. She also provided the wheelchair prescription, Resident A's *Resident Care Agreement*, dated 01/01/2023, the *Speech and Language – Dysphagia Care Plan*, and Resident A's *Nutrition Care Plan*, dated 05/2023. Upon my review of Resident A's assessment plan, it was consistent with the CEI CMH assessment plan and treatment plan; however, it stated, "transport wheel chair used when [Resident A] is unsteady or after eating to keep her sitting up for 1 hour."

Ms. Marshall also sent Resident A's physician contacts from 09/24/2022 through 05/09/2023. According to this documentation, Resident A's physician documented Resident A utilizing a wheelchair and her declining mobility over this time period.

On 06/06/2023, I received an email from Ms. Spencer containing Resident A's hospital discharge summary, dated 05/30/2023. She also provided a utilization review document from Resident A getting first admitted to the hospital.

According to my review of the discharge summary, Resident A was admitted to the hospital on 05/22/2023 at 11:23 am. The documentation indicated Resident A "presented from an AFC Facility following a Cardiac arrest noted on the morning of 05/22. Her caregiver was at her side when she suffered cardiac arrest and was noted to have pulseless and unresponsiveness. Her caregiver started the CPR immediately and which was later taken over by EMS".

According to my review of the utlization review, dated 05/23/2023, Resident A suffered cardiac arrest at approximately 10:50 am on 05/22/2023. The documentation stated the following:

> "Patient was said to be sitting in her wheel chair when she was noted to have slumped over pulesless and unresponsive. The care taker (who was also present at bedside) started CPR immediately and called EMS, CPR was continued for about 15mins[*sic*], when EMS arrived, they continued CPR and ROSC was achieved in 4 mins (Estimated 20-30mins down time). […] There is concern for hypoxia from pt. slumping over on her wheelchair with the seatbelt tugging on her neck- causing ant neck brusing."

The utilization review also identified bruising and ecchymosis around the anterior of Resident A's neck.

On 06/08/2023, Detective DeWitt played the 911 call for me. During the call, Ms. D. Dockery reported to dispatchers Resident A was not breathing, but Ms. A. Dockery was performing cardiopulmonary resuscitation (CPR). Ms. D. Dockery did not provide dispatchers with any information about how Resident A was discovered by her and Ms. A. Dockery. Detective DeWitt stated he had received reports and statements from the emergency responders; however, none of the reports or statements indicated either Ms. A. Dockery or Ms. D. Dockery told any emergency responders how Resident A had been found. Detective DeWitt stated emergency responders were only informed Resident A had been found on the facility floor. He stated her being discovered restrained under the seatbelt had not been relayed to any medical personnel.

O6/09/2023, I interviewed Resident A's CEI-CMH Supports Coordinator Ms. Spencer again. Ms. Spencer stated she had spoken to Ms. Marshall in the past about not using seatbelts as restraints. She stated she had emails documenting the correspondence. Ms. Spencer stated Resident A's wheelchair was only to be used as a transport wheelchair. She stated Resident A was ambulatory; however, she needed a wheelchair to transport her from the facility vehicle to her doctor appointments as she had a history of sometimes being unstable. She stated there was no documentation indicating the wheelchair was ordered to assist with keeping Resident A upright after meals or because Resident A was unsteady on her feet at the facility.

Ms. Spencer also sent me emails, which included email correspondences with Victoria Thomas, CEI's CMH care coordinator. Ms. Spencer indicated in her email correspondence to me that Ms. Thomas coordinated CEI CMH's contracts with facilities and licensees. She stated she would go to Ms. Thomas for assistance with "anything related to service provided by Central State.", the licensee. Ms. Spencer stated in her emails to me that Ms. Thomas "had several meetings with Dana Marshall and the director of Central State over the years".

Ms. Spencer also indicated in her emails to me that the attached emails included "overviewed phone conversations I had with Dana Marshall regarding the wheelchair and it's [sic] use." She also included a service note which documented the following: "based on observing [Resident A] in a wheelchair in January 2022 and then OT referral I placed in August 2022 for a proper review of a transport wheelchair for [Resident A]".

According to my review of this documentation, I established Ms. Spencer sent Ms. Thomas three emails, dated 01/26/2022, 04/21/2022, and 05/21/2022. The email sent on 01/26/2022 stated the following:

> "[Resident A] was sitting in a wheelchair throughout the visit. It looked like she was strapped in and I asked Brittani for verification that they were strapping her in. [Resident A] does not have an OT on her plan, therefore I know the wheelchair is not hers and there is no order for having her strapped in. I know she recently fell after being unsteady on her feet and received stitches in her face. I am thinking they are keeping her in the wheelchair when they only have 1 staff on shift in order get other things done. I have not yet reached out to an OT, but let me know what/should be done about that."

The email sent by Ms. Spencer to Ms. Thomas on 04/21/2023 stated the following:

> "After the incident in February where I observed [Resident A] in a wheelchair, I personally, have not seen

> that since. Per Dana [Dana Marshall, administrator], staff were informed on them not being able to utilize a wheelchair to keep [Resident A] "strapped" in. No formal recipient rights complaint was filed after speaking to the home and agreeing that there was a remedy to the situation. [Guardian A1] contacted me yesterday, April 20th, and informed me that he made a surprise visit to the house on Sunday, April 17th to visit [Resident A]. [Resident A] was indeed in a wheelchair and the seatbelt on, limiting her freedom of movement and ability to move around the home. Per [Guardian A1], it was reported to him that yes, she was placed in a wheelchair with the seatbelt on because they do not have more than 1 staff on shift and [Resident A] is getting into items and food that are unsafe to her while the single staff on shift is tending to personal care needs of others."

The email sent by Ms. Spencer to Ms. Thomas on 05/21/2022, stated the following:

> "Dana [Dana Marshall, administrator] had ended up calling me last to ask if I knew why there would be a meeting. I did inform her about the wheelchair incident that was reported to me from [Resident A's] family after their Easter visit. Dana informed me that she would be going to the AFC and removing any wheelchairs that are note[*sic*] assigned/prescribed to a specific individual and in use by that individual. She did mention [Resident A] may benefit from a transport wheelchair for appointments as she has been dropping to the floor as a refusal to walk, but also knew that any wheelchair needed a script and/or order from the doctor."

The service note provided by Ms. Spencer, dated 01/22/2022, confirmed Ms. Spencers statement about observing Resident A in a wheelchair. She also included in her email the referral request for Occupational Therapy (OT). The referral reason included the following:

> "[Resident A] struggles with ambulation specifically when walking in long distances in the community and at doctor's appointments. After arriving to a doctor appointment, [Resident A] will often get out of the van and then proceed to sit down and refuse to ambulate independently. OT request to review and receive options for a transport wheelchair."

On 06/13/2023, I received Resident A's death certificate from Ms. Spencer, which established Resident A passed away on 05/29/2023 at 4:24 pm. Her manner of death was listed as "Natural", but due to "Anoxic Brain Injury", "Cardiac Arrest", and "Developmental Delay". An autopsy was not performed.

On 06/30/2023, I interviewed Victoria Thomas, CEI CMH care coordinator. Ms. Thomas stated she was the liaison worker between the facility and CEI CMH. She stated her role was to provide support to the facility's DCWs, to offer the licensee and the licensee's management team and DCWs, as well as CEI's CMH staff with guidance, and to also be a point of contact for concerns brought up by CEI CMH supports coordinators. Ms. Thomas stated she had multiple meetings with the licensee's management team instructing them not to not use a wheelchair as a restrictive device with Resident A as there were concerns a wheelchair was being used as a restrictive measure. She stated during these meetings Ms. Marshall's supervisor, Jamilla Cheatom, had also been present. Ms. Thomas stated it appeared DCWs were utilizing the wheelchair's seatbelt to "strap" Resident A in because of "staff convenience" so they would know where Resident A was throughout the home while they were assisting with other residents. Ms. Thomas stated Ms. Marshall reported to her an in-service was provided to DCWs about restrictions; however, Ms. Thomas did not receive verification of this in-service.

Ms. Thomas stated it was addressed in meetings how DCWs were to have proper documentation to show the necessity of the wheelchair in order for it to be utilized. She stated prior to Resident A receiving a physician's order for a wheelchair in November 2022, it had been communicated to her the wheelchair had been removed from the facility.

Ms. Thomas forwarded me the meeting minutes, dated 03/07/2022, for the meeting between herself and Central State Community Services (Licensee) management, which included Paula (nee Ott) Barnes, the Licensee Designee, Dana Marshall, the Administrator, and Jamila Cheatom. According to these meeting minutes, Ms. Thomas brought up how Resident A was supported in a wheelchair and appeared to be strapped in without a current order in place for the wheelchair or a treatment plan supporting either one of these actions. Ms. Thomas asked if there was a reason Resident A was being strapped into the wheelchair, but Ms. Marshall indicated she had not seen Resident A in her wheelchair. Ms. Marshall reported to Ms. Thomas she had in-serviced all the homes on restrictions and went over the process with staff on changes where restraints are needed. Ms. Marshall reported to Ms. Thomas she had made it clear direct care staff could not do restrictions with any consumers. Ms. Thomas did ask Ms. Marshall if there was an increase in Resident A falling; however, it was determined Resident A was exhibiting normal behaviors like getting up too quickly after a nap.

An additional meeting was held with Ms. Thomas and Central State Community Services management, which included Jamila Cheatom, on 07/15/2022. The meeting minutes identified Ms. Barnes as absent. It was again brought up to the

licensee of a “repeated wheelchair incident” involving Resident A. The meeting minutes indicated Resident A is “being kept in a wheelchair and doesn’t need to be in the chair; seems to be more staff convenience; staff said it is to keep her safe. Jamila said all wheelchairs have been removed from the home.”

On 06/30/2023, I conducted a follow-up interview with Administrator, Dana Marshall. Ms. Marshall stated she was verbally told by Resident A’s physician that the seatbelt should be used on Resident A for “health and safety reasons.” Ms. Marshall stated her physician did not want Resident A getting up and moving around; however, she stated there was no documentation to verify these statements. Ms. Marshall stated then the wheelchair was used to keep Resident A sitting up right after she ate. She indicated if the seatbelt was not used on Resident A that she would get up and lay on her side. Administrator Dana Marshall stated it was never discussed or addressed with any DCWs about monitoring or supervising Resident A while she was sitting upright after eating. She stated DCWs would assist other residents or do other things while Resident A was strapped in the wheelchair. Ms. Marshall acknowledged she should have gotten a more “specific and detailed order” regarding the use of the wheelchair and seatbelt.

Ms. Marshall stated if Resident A was in the wheelchair without the seatbelt, then Resident A would turn to the side and curl up. She stated DCWs tried to redirect Resident A to sit upright; however, she would pull away from them. Ms. Marshall stated the utilization of a different type of wheelchair or seatbelt had not been discussed with Resident A’s physician or CMH contacts. Ms. Marshall stated that as far as she was aware, every time the seatbelt was on Resident A she would be sitting upright. She stated she was not aware of any previous incidences where she’d slipped under the seatbelt.

Ms. Marshall stated the facility’s former home manager, Holly Brown, who left in December 2022 had been told by CEI CMH not to use the wheelchair with Resident A. She stated Resident A had a swallow study completed in December 2022 and the orders for the upright position after eating were obtained in January or February 2023. Ms. Marshall denied the wheelchair or seatbelt being used for staff convenience like it had when Ms. Brown was the home manager.

On 07/06/2023, Ms. Marshall sent me via email a copy of a signed in-service form indicating she provided the facility’s DCW with an in-service on 08/30/2022 addressing assistive devices. According to the in-service, the discussion topic was “assisted devices” and included the following:

> “When using an assisted device for a resident we must have a doctor’s order/script. Assiste[*sic*] devices are external devices that are designed, made, or adapted to assist a person. Wheelchairs, walker, crutches, braces, gait belts, canes, hospital beds, rails etc. are a few

> examples of assisted devices. You can not [sic] use any assisted device without a doctor's orders/script."

Ms. Marshall did not have documentation confirming Ms. A. Dockery or Ms. D. Dockery also received this in-service regarding assistive versus restrictive devices.

On 07/11/2023, I received an email from Detective DeWitt confirming the following timeframe when Resident A was found unresponsive:

- DCW called 911 at 10:38 am
- EMS dispatched to the facility at 10:39 am
- EMS arrived to the facility at 10:41 am
- EMS left the facility at 11:00 am
- EMS arrived at hospital at 11:20 am
- Resident A was transferred to hospital care at 11:22 am
- EMS closed the call at 12:03 pm

On 07/12/2023, I conducted a follow up interview with DCW, Ms. A. Dockery, via telephone. Ms. A. Dockery stated she did not recall taking a training or receiving an in-service regarding assistive devices and restraints within the last year but recalled receiving a training at the time of her hire on using Hoyer lifts and transfer belts. I asked Ms. A. Dockery what she thought a restraint was and she replied, "holding someone down", but then she stated she was not able to explain. Ms. A. Dockery again stated the wheelchair was being utilized for Resident A because she was unsteady on her feet and falling. She stated the physician's order for the wheelchair stated, "as needed", which she indicated meant DCWs could use it when Resident A needed it. Ms. A. Dockery indicated Resident A's dietician, Darcy Whitney, provided her and DCWs with the instruction for the wheelchair and seatbelt being used to keep Resident A upright; however, Ms. A. Dockery stated she did not have any documentation of this specific instruction.

On 07/12/2023, I interviewed Guardian A1, via telephone. Guardian A1 stated when he was on his way to meet Ms. A. Dockery and Resident A at her neurologist appointment on 05/22/2023 when he received a telephone call from Ms. A. Dockery informing him Resident A had been discovered unresponsive and was taken to a local hospital's Emergency Room (ER). He stated he believed Resident A's medical appointment was at 11 am. Guardian A1 stated it was approximately 30 minutes to one hour after being in the ER that Ms. A. Dockery explained to the ER doctors how Resident A had been discovered. He stated it was at this point he learned Resident A had been restrained in her wheelchair while she and Ms. D. Dockery tended to the personal care of two of the other residents. Guardian A1 stated Ms. A. Dockery reported to him and the ER doctors that when she found Resident A she was tangled in the seatbelt and had to be cut out of it by Ms. D Dockery. Guardian A1 stated he observed red marks on Resident A's neck area at the ER prior to her getting "hooked up" to medical devices. He stated he took pictures and provided them to police. Guardian A1 also stated it had been communicated to him by the ER

doctors that they followed cardiac arrest procedures upon Resident A arriving to the ER because that it what was communicated to them rather than strangulation.

Guardian A1 stated he and his spouse visited with Resident A at least a couple times per month, in addition to, attending Resident A's medical appointments. He stated he observed Resident A secured in a wheelchair one time prior approximately a year ago and when he addressed it with DCWs they undid the seatbelt. He stated this information had been relayed to Ms. Spencer and he had not observed Resident A secured in a wheelchair since that time. Guardian A1 stated Resident A's wheelchair was only to be used for transporting her from the facility vehicle to medical appointments as Resident A would sit down in the medical office parking lot upon exiting the vehicle.

Guardian A1 stated Resident A's dietician recommended Resident A sit upright after eating to lessen her GERD symptoms; however, Guardian A1 stated there was never any discussion, authorizations, or approvals from himself or any of Resident A's physicians or CMH workers instructing DCWs to restrain Resident A upright in her wheelchair.

Guardian A1 stated Resident A was ambulatory and very active. He stated she would often curl into a ball in a recliner while getting comfortable. He also indicated if Resident A did not want to be in a situation or did not like something then she would get out of the situation. Guardian A1 provided an example of Resident A sliding off benches during medical appointments, which resulted in either himself or Ms. Spencer picking Resident A up. Guardian A1 stated Resident A was also not capable of undoing her lap seatbelt. Guardian A1 stated there had never been any discussion with him from any DCWs or anyone from the licensee or CMH about DCWs struggling to keep Resident A upright after eating in her wheelchair.

On 07/17/2023, CEI CMH Speech and Language Pathologist, Darcy Whitney, provided email correspondence documenting she neither had documentation nor instructed Ms. A. Dockery or Ms. Marshall to use a wheelchair and/or seatbelt to secure Resident A after eating or at any point during the day. She stated the only documentation and instruction provided to Ms. A. Dockery and Ms. Marshall were to keep Resident A in an upright position during her meals and for approximately 30 minutes after eating, which was outlined in Resident A's Dysphagia Care Plan.

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:	Based on my investigation, which included interviews with direct care workers Alex Dockery and Deborah Dockery, Administrator Dana Marshall, CEI CMH support coordinator Lauren Spencer, CEI CMH care coordinator Victoria Thomas, Guardian A1, and a review of Resident A's AFC documentation and CEI CMH documentation as well as documentation provided by CEI CMH relating to meeting minutes between CEI CMH and Central State Community Services management team and licensee designee, Paula Barnes, from March and July 2022, there is substantial evidence establishing facility staff did not provide Resident A with protection and safety on 05/22/2023 when she was placed in a wheelchair, strapped in with a seatbelt, which she was unable to unbuckle leaving Resident A restrained without assistance. DCW Ms. A. Dockery and Ms. D. Dockery left Resident A strapped into her wheelchair, unattended and without supervision, in the facility's living room from approximately 10:15 am until 10:38 am while they provided personal care to Resident B and Resident C. After Ms. A. Dockery provided personal care to Resident C, and entered the facility's living room, she discovered Resident A had slipped under the wheelchair lap seatbelt, with her neck entangled in the seatbelt, and was unresponsive, which consequently lead to Resident A's untimely death on 05/29/2023 from Anoxic Brain Injury and Cardiac Arrest. Of note, Resident A was so tightly tangled in the seatbelt direct care staff had to cut her out of the seatbelt as it was locked and would not unbuckle. Additionally, despite the Licensee, Central State Community Services, Inc., the Licensee Designee, Paula Barnes, the Administrator, Dana Marshall, being informed and reminded from CEI CMH about not using a wheelchair as a restraint with Resident A on multiple occasions in 2022 it continued to be utilized in such a manner. The licensee never received any specific order from any physician or therapist to utilize the wheelchair with seatbelt before, during or after Resident A ate or because Resident A was unsteady while inside the facility. Consequently, the use of the wheelchair and seatbelt being utilized as a restraint on Resident A contributed to her death on 05/22/2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A was restrained in her wheelchair by direct care staff.

INVESTIGATION:

The complaint alleged on 05/22/2023, Resident A slid down in her wheelchair and became stuck under the seatbelt. It was alleged Resident A was being restrained within the wheelchair with the use of the seatbelt. The complaint alleged Resident A was found unresponsive while stuck under the seatbelt and despite medical attention, she ultimately passed away from her injuries on 05/29/2023.

Ms. Spencer, Resident A's CEI CMH supports coordinator, stated Resident A was only prescribed a "transport wheelchair with seatbelt" to assist Resident A while she was being taken from the facility's vehicle to medical appointments as Resident A had displayed signs of unsteadiness on her feet. Ms. Spencer also stated to me that though Resident A was expected to sit upright in a chair for approximately 30 minutes to one hour after eating to prevent GERD symptoms, there was no physician's order allowing DCWs to secure Resident A in her wheelchair via a seatbelt. Additionally, Ms. Spencer stated Resident A did not have the dexterity or mental capacity to unlock or unclasp a seatbelt if she was secured within the wheelchair. Ms. Spencer stated she had addressed her concerns of DCWs restraining Resident A into a wheelchair on multiple occasions in 2022 after she observed Resident A secured in a wheelchair with a seatbelt during her visits at the facility. Ms. Spencer stated she relayed these concerns to the CEI CMH's care coordinator, Ms. Thomas, who then conducted meetings with the licensee and the licensee's management team, which included, Paula Barnes, Dana Marshall, and Jamilla Cheatom.

Ms. Thomas stated that as a result of her meeting with the licensee in July 2022, Ms. Cheatom removed the wheelchair DCWs were using for Resident A.

DCWs, Ms. A. Dockery and Ms. D. Dockery, and Administrator, Ms. Marshall all reported Resident A was unable to unlock or unclasp the seatbelt while in the wheelchair in order to get out of the wheelchair. They all denied utilizing the wheelchair and seatbelt for staff convenience. They all stated the wheelchair and seatbelt were utilized for Resident A's safety due to her being unsteady, at times, and to keep her upright for 30 minutes to one hour after eating. Ms. A. Dockery, Ms. D. Dockery, and Ms. Marshall all stated Resident A was non-verbal. They all also stated there was no plan or expectation for the supervision of Resident A while she was secured upright in her wheelchair for the required 30 minutes to one hour after eating.

Both Ms. A. Dockery and Ms. D. Dockery stated Resident A would not have been able to request or ask to get out of the wheelchair. Ms. A. Dockery stated she would

unsecure Resident A from the wheelchair after Resident A sat upright in it for the required time after eating to prevent GERD symptoms.

Ms. Marshall acknowledged she should have gotten more detailed order regarding the wheelchair and seatbelt from Resident A's physician.

During my inspection, I observed the wheelchair and the attached lap seatbelt with plastic push button that were utilized by Resident A on 05/22/2023. Using the viewpoint of sitting in the wheelchair, I observed the seatbelt had been cut on the wheelchair's left side approximately within 1 inch of the wheelchair seat. At the time of my inspection, the push button was functioning properly as Ms. Marshall demonstrated locking the seatbelt and unlocking it by pressing the push button. I took pictures of the wheelchair and seatbelt as part of my investigation.

I reviewed the prescription for Resident A's wheelchair, dated 09/26/2022, which included Resident A's name, the date, the physician's signature, her date of birth, her diagnosis of "autism" and "intellectual disability", and the order of "transport wheelchair with seatbelt PRN". There was no additional information included in the prescription.

Resident A's *Assessment Plan for AFC Residents*, dated 01/01/2023, identified the use of a wheelchair under the section of Special Equipment Used. This section included the information, "transport wheel chair used when [Resident A] is unsteady or after eating to keep her sitting up for 1 hour." Resident A's assessment plan was signed by Ms. Marshall, Resident A's responsible agency and Resident A's guardian.

Resident A's *Speech and Language – Dysphagia Care Plan and Speech Evaluation* were both consistent with the recommendation of Resident A sitting upright after eating for at least 30 minutes.

Guardian A1's statement to me was consistent with Ms. Spencer's statement to me. Guardian A1 denied any authorization or approval for the Licensee or any DCWs to restrain Resident A in a wheelchair with the use of a lap seatbelt.

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	Use of assistive devices. **(1) An assistive device shall only be used to promote the enhanced mobility, physical comfort, and well-being of a resident.** **(2) An assistive device shall be specified in a resident's written assessment plan and agreed upon by the resident or the resident's designated representative and the licensee.**

	(3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the authorization.
ANALYSIS:	There is substantial evidence DCWs were utilizing Resident A's transport wheelchair with a seatbelt as a restraint rather than an assistive device. Based on my investigation, DCWs Ms. A. Dockery and Ms. D. Dockery, along with Administrator, Ms. Marshall, all confirmed Resident A, who was non-verbal, was unable to remove herself from the wheelchair when the seatbelt was secured. Ms. Spencer also confirmed Resident A would not have had the dexterity or mental capacity to release the seatbelt, if needed. After Ms. A. Dockery secured Resident A in her wheelchair on 05/22/2023 with the seatbelt, she proceeded to leave Resident A unsupervised while she assisted another resident with personal care indicating the seatbelt was being utilized for the convenience of staff. While Resident A was left unsupervised, she failed to maintain an upright position and slid beneath the lap belt, where she was stuck for approximately 20 – 30 minutes until being discovered by Ms. A. Dockery. Though Resident A had a prescription for a "transport wheelchair with seatbelt PRN" there is no documentation or authorization in writing stating the reason for the wheelchair and seatbelt and the term of the authorization, as required. Additionally, there is no documentation, either in Resident A's assessment plan or from a medical physician or therapist, that Resident A could be *restrained* in an upright position for at least 30 minutes after eating, which DCWs were doing. Consequently, Resident A died from Anoxic Brain Injury and Cardiac Arrest after she was restrained to her wheelchair using a lap seatbelt.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of

	the licensee, employees, or any person who lives in the home shall not do any of the following: **(c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.**
ANALYSIS:	Though DCWs, Ms. A. Dockery and Ms. D. Dockery and Administrator, Ms. Marshall indicated Resident A's wheelchair and seatbelt were being utilized as an assistive device, there is substantial evidence establishing it was being utilized as a restraint. Despite the wheelchair and seatbelt being prescribed by a physician, the order only identifies "transport wheelchair with seatbelt PRN" rather than identifying the use of the wheelchair and seatbelt in assisting Resident A with sitting upright for at least 30 minutes after eating to prevent GERD symptoms. Interviews with Ms. A. Dockery, Ms. D. Dockery, Ms. Marshall, and CEI CMH supports coordinator, Ms. Spencer, all confirmed Resident A was unable to unlock the seatbelt to get out of the wheelchair, which establishes she was restrained to the wheelchair while the seatbelt was being utilized.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

In my interviews with DCWs Ms. D. Dockery and Ms. A. Dockery, neither DCW reported they informed EMS personnel about how Resident A was discovered on 05/22/2023. Though Ms. D. Dockery contacted 911 to report Resident A unresponsive, she failed to report how she became unresponsive, how she was discovered unresponsive, or the events that led to her cardiac arrest.

In my interviews with Detective DeWitt, he stated he obtained the EMS report, in addition to, approximately four to five statements from medical staff who came to the facility in response to the 911 call and neither the EMS report nor the statements from the EMS personnel indicated either Ms. A. Dockery or Ms. D. Dockery reported to any of these personnel that Resident A had been restrained in her wheelchair and had been discovered lodged or hanging under the seatbelt, which would have contributed to her becoming unresponsive. Additionally, neither DCW reported to EMS personnel that Resident A had to be cut out of the seatbelt due to it being stuck. Rather, Ms. A. Dockery and Ms. D. Dockery reported to 911 and EMS

personnel Resident A was found on the floor. Detective DeWitt stated due to EMS not being informed of how she had been discovered they subsequently did not take pictures or treat the area as a potential crime scene.

Additionally, according to my review of Resident A's discharge summary and the hospital's utilization review, dated 05/29/2023 and 05/23/2023, respectively, Resident A was admitted to the hospital on 05/22/2023 at 11:23 am due to suffering cardiac arrest. The documentation provided suggested Resident A's caregivers were "at her side" when she suffered cardiac arrest. The utilization review indicated that it was only once Resident A was in the hospital, several hours after she was admitted at approximately 4:33 pm, that hospital staff were informed Resident A had been sitting slumped over in her wheelchair, pulseless and unresponsive, for approximately 20-30 minutes. The medical documentation indicated there was concern Resident A had hypoxia due to the seatbelt "tugging on her neck".

Guardian A1 stated he was expecting to meet Resident A and DCW Ms. A. Dockery for Resident A's neurologist appointment, which he stated he thought started at 11 am on 05/22/2023. He stated he received a phone call from DCW Ms. A. Dockery prior to the appointment telling him Resident A was having cardiac arrest and she was being transported to a local hospital. Guardian A1 stated he arrived at the hospital shortly before Ms. A. Dockery. Guardian A1 stated he and his wife were at the hospital for approximately 30 minutes to one hour before Ms. A. Dockery described to him and attending physicians how she actually discovered Resident A in the facility. He stated Ms. A. Dockery described how she placed Resident A in the wheelchair and then she and Ms. D. Dockery attended to two other residents. He stated Ms. A. Dockery reported to him and attending physicians that when she returned to the living room, she found Resident A entangled in the wheelchair seatbelt. He stated she reported Ms. D. Dockery obtained scissors to cut the seatbelt and release Resident A. Guardian A1 stated Ms. A. Dockery reported Ms. D. Dockery called 911 while Ms. A. Dockery administered CPR. Guardian A1 stated the attending physician's reported they followed cardiac arrest protocol for Resident A since that is what was reported to EMS personnel at the time Resident A was discovered.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(b) Be capable of appropriately handling emergency situations.**

ANALYSIS:	Despite DCWs, A. Dockery and D. Dockery, contacting 911 upon discovering Resident A unresponsive on 05/22/2023, they both failed to relay how Resident A had been discovered unresponsive, which was she had been stuck or lodged under the wheelchair seatbelt, which had to be cut because it would not unclasp. Rather, the DCWs relayed to EMS personnel that they had been by her side when she suffered cardiac arrest and it was only several hours later that medical personnel at the hospital discovered Resident A had slipped under the wheelchair seatbelt unable to be released. Ultimately, neither DCW, A. Dockery nor D. Dockery, appropriately handled Resident A's medical emergency because they did not relay pertinent information upon EMS arriving to the facility so they could adequately conduct an assessment of not only Resident A's injuries, but also treat the area as a potential crime scene.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 07/18/2023, I conducted my exit conference with the licensee designee, Paula Barnes, via telephone. I explained my findings and recommendation to Ms. Barnes, which she acknowledged; however, she disagreed with the recommendation. I informed Ms. Barnes a compliance conference would be scheduled whereas at the time she could provide any additional documentation or information.

IV. RECOMMENDATION

Based on the willful and substantial quality of care violations resulting in the death of Resident A, I recommend revocation of the license.

07/12/2023

Cathy Cushman Date
Licensing Consultant

Approved By:

07/14/2023

Dawn N. Timm Date
Area Manager