GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 13, 2023

Janice Kutha
W9835 Co Road 352
Stephenson, MI 49887

RE: License #: AM550009068
Investigation #: 2023A0234019
Kutha AFC Home

Dear Janice Kutha:

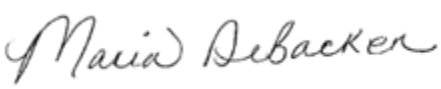
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please 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,



Maria DeBacker, Licensing Consultant
Bureau of Community and Health Systems
305 Ludington St
Escanaba, MI 49829
(906) 280-8531

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM550009068
Investigation #:	2023A0234019
Complaint Receipt Date:	09/15/2023
Investigation Initiation Date:	09/15/2023
Report Due Date:	11/14/2023
Licensee Name:	Janice Kutha
Licensee Address:	W9835 Co Road 352 Stephenson, MI 49887
Licensee Telephone #:	(906) 753-4880
Administrator:	Janice Kutha
Licensee Designee:	NA
Name of Facility:	Kutha AFC Home
Facility Address:	W9835 County Road 352 Stephenson, MI 49887
Facility Telephone #:	(906) 753-4880
Original Issuance Date:	05/30/1988
License **Status:**	REGULAR
Effective Date:	11/30/2022
Expiration Date:	11/29/2024
Capacity:	11
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was admitted to the hospital on 8/31/23, he had low blood sugar, and he was unresponsive. Resident A was found to have a left hip dislocation, closed fracture to the left femur and several pressure ulcers. Resident A was also in septic shock, had a UTI, and a lower GI bleed. Resident A had not walked for several weeks, and the home failed to seek immediate medical care.	Yes
Additional Findings	Yes

III. METHODOLOGY

09/15/2023	Special Investigation Intake 2023A0234019
09/15/2023	APS Referral
09/15/2023	Special Investigation Initiated - Telephone Discussed with CMH
09/20/2023	Inspection Completed On-site
09/20/2023	Inspection Completed-BCAL Sub. Compliance
09/29/2023	Contact - Document Received Cause of death document received.
10/31/2023	Contact - Document Received Email with Recipient right/documents received discussed.
11/6/2023	Contact - Document Received Documentation received from Home Manager.
11/6/2023	Contact - Document Received Documentation received from RRO
11/8/2023	Contact - Telephone call made Phone call to guardian

11/8/2023	Contact - Telephone call made Phone call placed to Stacie Murray, PCP
11/8/2023	Contact - Document Sent Fax sent to Stacie Murray requesting a phone call to discuss case
11/13/2023	Contact - Telephone call made Call to Stacie Murray's office to confirm fax was received
11/13/2023	Exit Conference Exit Conference with Licensee Janice Kutha

ALLEGATION: Resident A was admitted to the hospital on 8/31/23, he had low blood sugar, and he was unresponsive. Resident A was found to have a left hip dislocation, closed fracture to the left femur and several pressure ulcers. Resident A was also in septic shock, had a UTI, and a lower GI bleed. Resident A had not walked for several weeks, the home failed to seek immediate medical care.

INVESTIGATION: On 9/20/2023 An unannounced inspection was made at the home. Home Manager (HM) Jada Nemi was interviewed. Jada Nemi stated that on Sunday August 27th, 2023, Resident A had a light loose stool and red hips. A&D ointment was applied to both hips. Jada Nemi stated that on Monday August 28th the redness had a "blistery look". She stated there was also a sore on Resident A's coccyx. Tuesday, she cleaned Resident A and added sterile pads to the A&D ointment. Jada Nemi stated that on Wednesday the blisters/wound broke open. Jada Nemi stated that she continue to treat the wounds with A&D ointment and bandages into Thursday.

HM Jada Nemi stated that on Thursday Resident A had some oatmeal for lunch but then chose to take a nap instead of finishing. At 1:00pm Resident A laid down for a nap and Jada Nemi says she checked on Resident A periodically. Just before 3:00 pm Jada Nemi stated that Resident A's demeanor changed, and Resident A was not responding. Resident A had a shallow pulse Jada Nemi called 911 who was able to find a pulse. EMT's stated that his glucose was low, and oxygen was low. Jada Nemi stated that once at the hospital she was informed that Resident A had a hip fracture and had a sepsis infection. Resident A was transferred to a hospital in Green Bay WI.

On 9/1/2023 an Incident Report was received from Jada Nemi stating that Resident A was napping and became unresponsive and sent to the hospital on 8/31/2023. It stated that Resident A had a urine infection causing sepsis, pressure sores, and a dislocated hip. It also stated that Resident A was transferred to Green Bay for a GI bleed. This report was signed by Jada Nemi and Janice Kutha.

On 9/5/2023 an Incident Report was received from Jada Nemi stating that she was informed by a family member that Resident A had passed away. This report was signed by Jada Nemi.

On 9/05/2023, Residents B, C, and D were observed during the on-site interview. They appeared to be clean and receiving adequate care. Residents B, C, and D are mostly nonverbal and were not interviewed but did exchange pleasantries and smiles.

On 9/20/2023 during this onsite investigation incident reports were reviewed and support the statements made by Jada Nemi during this interview.

On 9/20/2023 Resident A's records were reviewed. On April 18, 2023, Resident A was seen by the PCP Stacy Murray. It was noted that the PCP ordered an endoscopy and a colonoscopy on April 18, 2023, that were never completed or arranged. Jada Nemi stated that the guardian did not want extra testing done (refusal of colonoscopy and endoscopy by the guardian was confirmed by Northpointe CMH). The guardian denied refusal however Kutha AFC cannot refuse to comply with doctors' orders even if the guardian refuses. Jada Nemi stated that Resident A often refused to leave the home and it was hard to get Resident A to the doctor. Records did not indicate that Resident A had a history of decubitus ulcers. Resident A's Health appraisal stated that Resident A was fully ambulatory with assistance. According to the documentation Resident A was diagnosed with Agoraphobia and had a fear of falling and anxiety. Over the years Resident A would at times refuse to walk out of fear. (This was supported by Recipient Rights office Katie Smith, his guardian and documentation in his record).

HM Jada Nemi stated that Resident A was able transfer in and out of bed without assistance although Resident A was supposed to ask for help for safety. Jada Nemi stated that it is possible that Resident A could have fallen and gotten back up without staff knowing of the fall. Resident A was diagnosed with Agoraphobia and had a fear of falling and anxiety. Over the years Resident A would at times refuse to walk out of fear. (This was supported by Recipient Rights office Katie Smith, his guardian and documentation in his record). Jada Nemi stated that when Resident A stopped walking, they did not correlate that with injury as it has happened several times in the time that Resident A lived in the home.

On 11/8/2023 a contact was made to Stacy Murray, PCP, office. The office secretary requested a written request for Stacie Murray to discuss the case as the file was closed due to death. A written request was faxed on 11/8/23. On 11/13/23 a phone call was placed to the office of Stacie Murray, and it was confirmed that the fax request was received on 11/8/23. Stacie Murray had not yet contacted me at the writing of this report.

On 11/8/2023, contact was made with Family Member A. Family Member A stated that Resident A has lived at the Kutha AFC for over 4 years and was always happy

there. Family Member A said that there were never concerns about the care received in the home until hospitalization on 8/31/2023. Family Member A was very upset about the broken hip and bed sores and stated that frustration was taken out on Jada Nemi. Family Member A stated that now Family Member A feels better about the situation and has apologized to Jada Nemi. Family member A stated that when Resident A was initially place it was stated that Resident A had anxiety and extensive medical testing was discussed and refused. Family Member A does not recall being asked about testing since and does not feel testing would have been refused.

On 9/21/2023 Family Member A was interviewed by RRO Katie Smith. Family Member A is Resident's A's aunt and guardian. Family Member A told RRO Katie Smith that no concerns were noted during Resident A's time at Kutha AFC. Family Member A felt that Resident A was happy with Jada Nemi and was treated like family. Family Member A stated that there was limited contact with Jada Nemi and the case manager. After Resident A's death Family Member A was angry with Jada Nemi and blamed the AFC but Family Member A feels better about the situation now.

On 9/29/2023, the coroner's report was obtained, and it stated that the manner of death was an accident and that Resident A's immediate cause of death was complications of hip fracture.

On 11/6/2023, an email that was sent 11/5/2023 was received from Jada Nemi provided a certificate stating that she was trained in Wound Prevention and Management on 8/7/2023. Research done by RRO Katie Smith, and I indicate that best practice is to seek medical attention immediately when pressure sores blister whether they are open or not. Jada Nemi stated that Monday and Tuesday the one on his coccyx was blistered as well. That means they are Stage 2 and medical attention should be sought at that time.

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:	Jada Neimi stated that Resident A's blisters appeared on 8/28/23 and burst on 8/30/23. Resident A did not receive medical care until 8/31/23.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Resident A's PCP (Primary Care Physician) ordered testing in April that was not completed.

INVESTIGATION: On 9/20/2023 while interviewing Jada Nemi, home manager, records were reviewed. On April 18, 2023, Resident A was seen by the PCP Stacy Murray. Records indicate that PCP Murray was seeking the guardian's information. Jada Nemi stated that information was provided to the secretary at the office on 2 occasions, but the notes indicate that the PCP office did not have that information. It was also noted that the PCP ordered an endoscopy, stool sample and a colonoscopy on April 18, 2023, that were never completed or arranged. Jada Nemi stated that the guardian did not want extra testing done but admitted the stool sample should have been completed (refusal of colonoscopy and endoscopy by the guardian was confirmed by Northpointe CMH). Jada Nemi stated that Resident A often refused to leave the home and it was hard to get Resident A to the doctor.

On 11/13/2023 an exit interview was conducted with Janice Kutha licensee. The findings of this report were discussed.

On 9/21/2023 Family member A was interviewed by RRO Katie Smith. Family member A could not recall if Jada Nemi told her about the recommendation for a colonoscopy or EGD. Family member A feels a colonoscopy would have been approved.

On 11/8/2023 contact was made with Family Member A. Family Member A stated that Resident A has lived at the Kutha AFC for over 4 years and was always happy there. Family Member A stated that when Resident A was initially place it was stated that Resident A had anxiety and extensive medical testing was discussed and refused. Family Member A does not recall being asked about testing since and does not feel testing would have been refused.

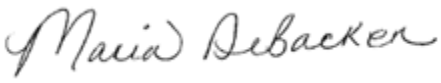
APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(a) Medications.** **(b) Special diets.** **(c) Susceptibility to hyperthermia and hypothermia and related limitations for physical activity, as appropriate.** **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**

ANALYSIS:	Resident A's PCP ordered an endoscopy, stool sample and a colonoscopy in that were never completed or arranged. The home failed to follow doctor's orders.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/13/2023 an exit interview was conducted with Janice Kutha licensee. Findings of this report were discussed.

IV. RECOMMENDATION

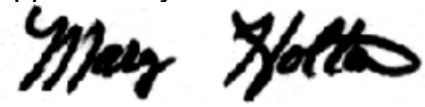
Contingent upon receipt of an acceptable corrective action plan, no changes to this license are recommended.



11/13/2023

Maria DeBacker Date
Licensing Consultant

Approved By:



11/13/2023

Mary E. Holton Date
Area Manager