GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 29, 2023

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

RE: License #: AS520282703
Investigation #: 2024A0873001
Ontario

Dear James Pilot:

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

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 643-7960.

Sincerely,

Garrett Peters, Licensing Consultant
Bureau of Community and Health Systems
234 W. Baraga Ave.
Marquette, MI 49855
(906) 250-9318

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS520282703
Investigation #:	2024A0873001
Complaint Receipt Date:	10/05/2023
Investigation Initiation Date:	10/05/2023
Report Due Date:	12/04/2023
Licensee Name:	Bay Human Services, Inc.
Licensee Address:	PO Box 741 3463 Deep River Rd Standish, MI 48658
Licensee Telephone #:	(989) 846-9631
Administrator:	Tammy Unger
Licensee Designee:	James Pilot
Name of Facility:	Ontario
Facility Address:	2262 Norwood Street Marquette, MI 49855-1340
Facility Telephone #:	(906) 228-5500
Original Issuance Date:	08/21/2006
License Status:	REGULAR
Effective Date:	12/12/2021
Expiration Date:	12/11/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 10/4/22, Resident A arrived at the hospital with a broken leg. Resident A was found to have an old fracture to her humerus and dislocated shoulder through medical imaging completed. Resident A is not ambulatory, and there is concern of how Resident A obtained these injuries.	No
Additional Findings	Yes

III. METHODOLOGY

10/05/2023	Special Investigation Intake 2024A0873001
10/05/2023	APS Referral Referred to APS
10/05/2023	Special Investigation Initiated - Telephone Interview with Jessica Lindgren, regional manager Bay Human Services
10/12/2023	Inspection Completed On-site
10/12/2023	Contact - Face to Face Interview with Staff
10/12/2023	Contact - Face to Face Interview Resident A
11/20/2023	Contact - Telephone call made Interview with Resident A guardian
11/20/2023	Exit Conference - Conducted with Tammy Unger, administrator
11/21/2023	Contact – Telephone call made Interview with home manager Kim Koski
11/22/2023	Inspection Completed Onsite Interview with home manager and review of Resident A's file.
11/29/20203	Exit Conference - Conducted with Tammy Unger – administrator

ALLEGATION: On 10/4/22, Resident A arrived at the hospital with a broken leg. Resident A was found to have an old fracture to her humerus and dislocated shoulder through medical imaging completed. Resident A is not ambulatory, and there is concern of how Resident A obtained these injuries.

INVESTIGATION: On 10/5/23 I received a phone call from Bay Human Services regional manager Jessica Lindgren. Manager Lindgren was calling to report to me that, the night before, Resident A was found in her bed with a broken femur. I was told that, while doing their scheduled rounds to observe residents, midnight staff discovered the leg was bent at a weird angle and her leg was cold to the touch. Staff called emergency services and was taken to the hospital where Resident A had surgery on her leg. While at the hospital, it was discovered that Resident A also had a dislocated right shoulder.

On 10/12/23, I conducted an unannounced, onsite inspection of the facility to interview Resident A as well as staff members of the home. Also in attendance were Casey O'Connor, Pathways Community Mental Health recipient rights officer, and regional manager Lindgren. I requested any incident reports showing a history of seizures for Resident A and was given four incident reports. The first three were dated 11/11/2022, 11/28/2022, and 12/07/2022. These incident reports detail staff coming into Resident A's bedroom after hearing her cry out and finding her amid a seizure. At times, according to the incident reports, these seizures appear to involve Resident A's arms, legs, and head flailing about erratically while she is vocalizing. The fourth incident report, dated 10/4/2023 at 1am, details the home manager receiving a call at 12:44am stating Resident A's left leg looked weird, her leg was cold to the touch, and she was not moving it. The home manager arrived at the home to evaluate her leg, determined she had a tibial pulse, and called EMS at 1:08am. The incident report goes on the explain that Resident A's guardian was notified early that morning.

On 10/12/23, I interviewed staff member Britney Hermanson. Staff Hermanson reported that she was working on the midnight shift the night the broken leg was discovered. Staff Hermanson told me that she arrived at the home on 11/03/23 at 11:25pm to work her shift with another staff person named Anthony Prychitko. Staff Hermanson and staff Prychitko relieved staff members Pamela Belmore and Tianna Pharr who had worked the evening shift. Staff Hermanson told me that the first hour she worked her shift there was no noise in the home, all residents were quiet and in their room. At 12:30am she began to do her routine resident checks. Upon entering Resident A's bedroom, she noticed that Resident A was awake and staring toward the door. Resident A is nonverbal and her staring at the door was a sign that she may need assistance. Staff Hermanson noticed that Resident A's leg was at a weird angle and that it was cold to the touch, so she called staff Prychitko to come into the bedroom. Staff Hermanson told me that she believed Resident A had just suffered a seizure. Staff Hermanson and Prychitko decided to contact the home manager to have her come to the home to assess the situation. I was told the manager was there within 15 minutes, at which time staff contacted EMS. Staff Hermanson told

me that she believes the broken femur was the result of a seizure. Resident A uses a hoyer lift to transfer and I asked staff Hermanson if she believes Resident A could have fallen while being transferred. She told me that that is not aware of any instances of a resident being dropped while using a Hoyer lift and believes staff would have reported this if it would have happened.

Also, on 10/12/23, I interviewed staff member Anthony Prychitko. Staff Prychitko told me that when he arrived at the home that night, Staff Prychitko and Britney split the resident bedrooms to do their checks. At a certain point, staff Hermanson called to him to come into Resident A's bedroom. Staff Prychitko told me that when he entered the room, he noticed Resident A's sheet was not on her and could tell there was something wrong. They were in the room for under one minute and decided to call the home manager. Staff Prychitko told me that Resident A seemed to have just had a seizure, wasn't making noise, and was moving her right leg while her left leg was bent at an awkward angle. Staff Prychitko told me that he is not aware of any instances of residents every falling out of their Hoyer lift and believes the leg break occurred during a seizure. He told me he was not aware of the dislocated shoulder until the next day but reported that, several times when EMS was there, the home manager was asking them to be more careful as they were working on transferring Resident A.

On 10/12/23, I interviewed staff member Pamela Belmore. Staff Belmore told me that she was working the shift before the leg was discovered. I was told that staff member Tiana Pharr was the only that performed the Hoyer transfer to put Resident A in bed. Staff Belmore told me that she has witnessed Resident A's seizures and has often witnessed her trashing about while they occurred. That shift, however, staff Belmore told me that Resident A seemed fine all night and was put to bed at 10pm. Staff Belmore told me that Resident A has a habit of crossing her legs when she is in bed. She believes the broken leg could have been the result of a seizure while having her legs crossed. Staff Belmore also told me she is not aware of any incidents of residents falling or being dropped while using a Hoyer lift.

On 10/12/23, I interviewed staff member Tiana Pharr. Staff Pharr told me that she was the one that transferred Resident A to bed that night. Staff Pharr told me the transfer was uneventful and Resident A was covered and in bed by 10:20pm. She told me that she has witnessed Resident A have seizures in which her legs and arms were flailing about. Staff Pharr believes the broken leg must have occurred during a seizure sometime between 10:30pm and 12:30am.

On 10/12/23, I attempted an interview with Resident A, however, Resident A is largely non-verbal, only able to communicate with gestures and vocalizations. Resident A was in her bed recovering from surgery as a result of the broken leg. She appeared content and did not seem to be in any distress. Her bed was up against the wall on one side, with the Hoyer lift nearby, with no bars on her bed. She seemed to be laying within a depression in the center of the bed which is designed for individuals that may have seizures to prevent them from falling out of bed. During

my time at the home, all residents I observed seemed happy, clean, and well-taken care of.

On 11/20/23 I conducted an interview with Resident A's guardian. Resident A's guardian was aware of the incident and told me that while at the hospital it was discovered that Resident A also had cancer. Resident A has since been put on hospice at the home. Guardian A believes it was possible that Resident A could have broken her leg during a seizure as she has been known to thrash around while they are occurring. Overall, Guardian A told me that she is happy with the care Resident A has received while at the home and Resident A's other relatives have been happy as well.

On 11/21/23 I interviewed home manager Kim Koski. Manager Koski told me that Resident A uses a bed with a holster designed for individuals that have seizures. Resident A did not have any bars on her bed that could have caused the leg fracture. When asked about what may have caused Resident A to have broken her leg, manger Koski told me that, at the hospital, the doctor told her that due to Resident A's osteoarthritis and inability to walk, her leg bones may have become so brittle that a violent enough seizure may have stretched the leg enough to cause a fracture. Manager Koski told me that it never crossed her mind that staff may have intentionally hurt Resident A and she is certain that staff on duty during the incident would have called her and told her if a fall had occurred. I told manager Koski that staff I interviewed told me that she had told EMS to be more careful and asked what this was about. Manager Koski told me that EMS personnel had Resident A swaddled in a blanket to transfer her but were doing so roughly. Manager Koski told me that her and her staff could have done a better job of transferring Resident A.

On 11/22/23, I conducted an onsite inspection at the home to interview home manager Kim Koski and reviewed Resident A's file. Home manager Koski showed me a form created by Bay Human Services to record details about Resident A's seizures. I reviewed the forms beginning January 1st of 2023. The forms show that Resident A was averaging 2-3 seizures per month until about June. There was one recorded seizure in October and another in November. When I asked about this home manager Koski told me that in May, Resident A's doctor increased her daily seizure medication, carbamazepine, from 100mg daily to 600mg daily. This had the effect of greatly reducing the number of Resident A's seizures. The reports also indicate that, more often than not, Resident A's seizures involve her convulsing and thrashing her arms and legs. I was also told that Resident A has a vagus nerve stimulator implant in her back. Staff are trained to scan this implant every 2 minutes when Resident A is having a seizure. Staff are also trained to give Resident A a dose of diazepam if the seizure lasts more than 5 minutes, and another dose if the seizure continues beyond the 10-minute mark. If the seizure does not stop within the first 5 minutes of this second dose, staff are to call 911. Staff did not follow this protocol because they found Resident A post-seizure. They were not aware of the length of the seizure. The home's medication record details this information and also has these instructions written in it. I also was able to review Resident A's

assessment plan which indicates her propensity for seizures, the fact that she uses a wheelchair for mobility, and that staff are trained in proper protocols when a seizure occurs. Resident A's health care appraisal also indicates the potential for seizures. I asked home manager Koski about any diagnosis Resident A may have that makes her bones more brittle than they otherwise would be. Home manager Koski told me that Resident A does not have a specific diagnosis to this effect but was told by the attending physician that patients that have an inability to use their limbs may experience loss of bone density due to nonuse. Further, home manager Koski was told that the surgeon inadvertently created a further fracture in Resident A's leg when he attempted to place in a pin in her femur during surgery, due to the femur's fragility.

Also, on 11/22/23, I received a copy of and was able to review the medical records for Resident A's time at the hospital. The records report that, during a chest x-ray, medical staff discovered an anterior dislocation of the shoulder. Due to Resident A having a "chronic deformity at the Hill-Sachs lesion with flattening of the humeral head from its articulation with the glenoid" it was determined that Resident A's "shoulder dislocation is definitely chronic." The records also explain that medical staff believe the femur fracture may be pathological due to the fact that there was "no trauma" at the site of the break. The medical records indicate that images taken of the leg show a spiral facture at the site of surgery believed to be caused by the insertion of a nail/screw during surgery. Further, the records indicate that this was most likely caused by the fact that Resident A has "significantly osteoporotic bone."

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:	After interviewing several staff members about the incident as well as Resident A and her guardian, I find no evidence of intentional injury or unreported accident that could have resulted in Resident A's broken leg. Resident A's medical records indicate significant osteoporotic bone most likely caused the factures discovered.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS: Staff did not immediately contact EMS when Resident A was discovered to have a broken leg.

INVESTIGATION:
On 11/22/23, Staff Hermanson stated on or about 11/5/23, at 12:30am Staff Hermanson began to do her routine resident checks. Upon entering Resident A's bedroom, she noticed that Resident A was awake and staring toward the door. Staff Hermanson noticed that Resident A's leg was at a weird angle and that it was cold to the touch, so she called staff Prychitko to come into the bedroom. Staff Hermanson told me that she believed Resident A had just suffered a seizure. Staff Hermanson and Prychitko decided to contact the home manager to have her come to the home to assess the situation. I was told the manager was there within 15 minutes, at which time staff contacted EMS.

On 11/29/23, I conducted an exit conference with Tammy Unger, administrator. I told Tammy Unger the result of the investigation including a rule violation regarding the delay in staff contacting EMS after discovering Resident A with a broken leg. Administrator Unger had no issue with me finding the rule violation and told me that they would retrain staff to be sure they understand the need to immediately contact EMS in emergency situations.

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:	Upon staff discovering Resident A with a broken leg, rather than immediately contact EMS as required by AFC policy, staff contacted the home manager and waited for her to arrive, assess the situation, and then contact EMS.
CONCLUSION:	**VIOLATION ESTABLISHED**

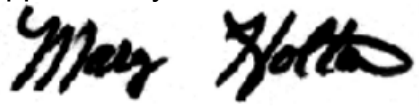
IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend no changes to the status of this license.

11/29/2023

Garrett Peters — Date
Licensing Consultant

Approved By:



11/29/2023

Mary E. Holton — Date
Area Manager