GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 12, 2024

Michael Kirby
Kirby's Adult Foster Care Services Inc.
2285 E. Lily Lake
Harrison, MI 48625

RE: License #: AS370408026
Investigation #: 2024A1029017
Shady Oak

Dear Mr. Kirby:

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.

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.

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 (231) 922-5309.

Sincerely,

Jennifer Browning

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
Browningj1@michigan.gov - (989) 444-9614

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS370408026
Investigation #:	2024A1029017
Complaint Receipt Date:	12/04/2023
Investigation Initiation Date:	12/05/2023
Report Due Date:	02/02/2024
Licensee Name:	Kirby's Adult Foster Care Services Inc.
Licensee Address:	2285 E. Lily Lake Harrison, MI 48625
Licensee Telephone #:	(989) 430-8061
Administrator:	Michael Kirby
Licensee Designee:	Michael Kirby
Name of Facility:	Shady Oak
Facility Address:	9320 E Pickard Mt Pleasant, MI 48858
Facility Telephone #:	(989) 317-3940
Original Issuance Date:	06/17/2021
License Status:	REGULAR
Effective Date:	12/17/2021
Expiration Date:	12/16/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On November 26, 2023 both direct care staff members Ms. O'Hara and Ms. Henkes were asleep during third shift and did not hear Resident A fall out of bed until she was crawling out of her bedroom.	Yes

III. METHODOLOGY

12/04/2023	Special Investigation Intake 2024A1029017
12/04/2023	Contact – Telephone call received from licensee designee Michael Kirby.
12/05/2023	Special Investigation Initiated – Letter to Angela Wend, ORR
12/08/2023	Contact - Face to Face with Matthew Hopper at another licensed facility.
12/19/2023	Inspection Completed On-site - Face to Face with direct care staff members Tanja Lalk, Jasmine Parker, and Resident A at Shady Oak.
12/27/2023	APS Referral made to Centralized Intake
12/27/2023	Contact - Telephone call made to Kali Dana, Bridget Henkes (left message), Kelly O'Hara (left message), Angela Wend ORR
01/02/2024	Contact - Telephone call made to Bridget Henkes (left message), Kelly O'Hara (left message)
01/03/2024	Contact - Telephone call made to Bridget Henkes, Kelly O'Hara, text to Kali Dana, CMH case manager Andrea Cotter, Angela Wend ORR
01/04/2024	Exit conference with licensee designee Michael Kirby, Left message for him.

ALLEGATION:

On November 26, 2023 both direct care staff members Ms. O'Hara and Ms. Henkes were asleep during third shift and did not hear Resident A fall out of bed until she was crawling out of her bedroom.

INVESTIGATION:

On December 4, 2023, a complaint was received via the Bureau of Community and Health Systems online complaint system with concerns that on November 26, 2023 both direct care staff members Ms. O'Hara and Ms. Henkes were asleep during third shift and did not hear Resident A fall out of bed until she was crawling out of her bedroom.

On December 4, 2023, I interviewed licensee designee, Michael Kirby. Mr. Kirby stated direct care staff members are required to always be awake at night and there are always two direct care staff members scheduled per night unless someone calls in. Mr. Kirby stated there was an incident where both direct care staff members fell asleep and a resident fell. Mr. Kirby stated he had his manager report the incident to Office of Recipient Rights (ORR) and an *AFC Incident / Accident Report* was completed. Mr. Kirby stated at this time, neither direct care staff member admitted to this. Mr. Kirby stated Resident A will sometimes lose her balance and fall so he was not surprised that she fell onto the floor and was crawling toward them. Mr. Kirby stated direct care staff member Ms. Parker, who was not working that evening, was informed by Ms. Henkes that she felt bad she fell asleep and did not hear Resident A fall from her bed. Mr. Kirby stated Resident A requires the use of a gait belt for mobility assistance due to her balance issues. Mr. Kirby stated after Resident A fell out of bed, she crawled her way toward the two direct care staff members which was when they woke up. Mr. Kirby stated Resident A is non-verbal and cannot communicate well so he does not know if she tried to cry out to receive assistance.

On December 19, 2023, I completed an unannounced on-site investigation at Shady Oak and interviewed direct care staff member whose current role is assistant home manager, Tanja Lalk. Ms. Lalk stated there is a clear policy regarding staying awake during third shift. Ms. Lalk stated there are always two direct care staff members working during third shift and there are usually no issues regarding direct care staff members staying awake during their shifts. Ms. Lalk stated direct care staff member Jasmine Parker was told by direct care staff member Bridget Henkes that she and another direct care staff member Kelley O'Hara both fell asleep during the shift and when they awoke, Resident A was on the floor coming toward them.

During the on-site investigation, I reviewed Ms. O'Hara and Ms. Henke's employee records. Ms. O'Hara did not have any concerns or discipline noted in the file for sleeping on shift. Ms. Henkes did have a written reprimand for sleeping on shift after she was talked to about it on September 7, 2023. I reviewed the training records for Ms. O'Hara and Ms. Henkes and confirmed both employees completed all required licensing trainings.

Both employees also signed the Shady Oak AFC Employee Conduct which clearly states:

"Employees shall always be awake while on duty. Sleeping on duty is prohibited."

I also observed Resident A's bedroom which is at the end of a small hallway. Resident A has a physician's order for a hospital bed with bed rails however, she can still get out of her bed. I observed the distance from Resident A's bedroom to the living area where Ms. Henkes was sitting at the time of this incident. I judged it to be a fair distance even though Resident A's bedroom was visible from the living area.

Ms. Lalk stated as a result of this incident, she has been working with Resident A's Community Mental Health case manager, Andrea Cotter to have a bed and seat alarm installed to alert direct care staff members when Resident A is attempted to get out of bed. Ms. Lalk stated Resident A can walk but not well so a gait belt is regularly used to assist with mobility and to steady Resident A while walking. Ms. Lalk stated they wake Resident A up at 3 AM to use the restroom each night. Ms. Lalk stated Resident A will wake up sometimes and look for her rings because they take them off her at night.

I reviewed the *AFC Incident / Accident Report* written by Ms. O'Hara on November 26, 2023 at 4:25 AM:

"Explain what happened: [Resident A] was falling out her doorway. She fell forward onto her hands. Staff witnessed the fall. Staff ran to help her. She was tangled up in her bedding.

Action taken: Checked her over. No marks seen currently.

Corrective measures: Staff to monitor."

Ms. Lalk stated she does not know how long Ms. Henkes and Ms. O'Hara were sleeping or if they woke Resident A up to use the restroom at 3 AM as scheduled.

I reviewed Resident A's *Assessment Plan for AFC Residents* which stated she does not move independently in the community and is assisted by a wheelchair and gait belt f*or assistance*. Under the section titled *Walking / Mobility, Resident A's Assessment Plan for AFC Residents* documented the following: "Staff assist gait belt all the time, wheelchair in the community."

On December 19, 2023, I interviewed direct care staff member Jasmine Parker at Shady Oak. Ms. Parker stated she knew that Ms. Henkes was working the night Resident A fell because Ms. Henkes informed her that while working her shift with Ms. O'Hara both fell asleep. Ms. Parker stated Ms. Henkes informed her when Ms. O'Dell woke up, Resident A was crawling toward her trying to receive assistance so she woke up Ms. Henkes. Ms. Parker stated Resident A went to the hospital the next day because she had hip pain which is believed to be a result of the fall. Ms. Parker stated she has

worked with Ms. Henkes in the past on second shift and she observed Ms. Henkes to fall asleep on more than one occasion. Ms. Parker stated she does not know if Resident A was woken up to use the restroom at 3 AM.

On December 27, 2023, I interviewed direct care staff member whose role is the home manager, Kali Dana. Ms. Dana stated she has not addressed this concern with direct care staff members Ms. Henkes and Ms. O'Hara because of the pending investigation. Ms. Dana stated she had issues with Ms. Henkes falling asleep when she first started on second shift and she was written up for that however there have been no recent issues. Ms. Dana stated Resident A has a non-video monitor in her room and a seat alarm for her wheelchair in the living room which would alert direct care staff members to a possibly fall.

On December 27, 2023, I interviewed ORR Angela Wend who stated she completed her 30 day report and she will likely be substantiating for neglect because they were both asleep during the time Resident A fell. Ms. Wend stated she still need to interview Ms. Henkes and Ms. O'Hara regarding the concerns.

On January 3, 2024, I interviewed direct care staff member Kelly O'Hara. Ms. O'Hara stated she was working on November 26, 2023 and Resident A fell coming out of her bedroom but she could not get to her fast enough. Ms. O'Hara stated she could not get to her in time because she was in the kitchen cooking and cleaning so by the time she heard her fall from her bed, Resident A was attempting to come out of her bedroom with her sheet around her ankle and the rest of it was on her bed. Ms. O'Hara stated there is now a chair alarm for Resident A which they did not have before, a non-video monitor, and they are working with the case manager to get a bed alarm. Ms. O'Hara stated she does not sleep during her shift and denied sleeping at all while working. Ms. O'Hara stated Ms. Henkes sleeps on a regular basis when she works with her on third shift and she has brought this to the attention of Ms. Dana to address. Ms. O'Hara stated if Ms. Henke was awake she would have heard her fall and she would have been able to get to her sooner because of where she was asleep near the window in the living room. Ms. O'Hara stated when she heard Resident A fall, she called out for Ms. Henkes who then woke up to assist her. Ms. O'Hara stated after the fall, she used Resident A's gait belt to assist her up and assessed her for any injuries. Ms. O'Hara stated Resident A did not appear to be in any pain at the time and she went back to sleep without further concerns. Ms. O'Hara stated she also looked her over and made sure there were no injuries in the morning when she was getting her ready and she did not see any areas of concern. Ms. O'Hara stated it is not unusual for Resident A to try and get up through the night.

On January 3, 2024, I interviewed direct care staff member Bridget Henkes. Ms. Henkes stated she regularly works with Resident A who requires a gait belt for mobility assistance. Ms. Henkes stated she was working when Resident A fell on November 26, 2023 and it is not unusual for her to fall during the night when she tries to get up. Ms. Henkes stated there is a policy against sleeping in the workplace including during third shift. Ms. Henkes initially denied she had ever fallen asleep at work and stated she was

not asleep at the time Resident A fell. Ms. Henkes was unable to give details of how Resident A fell. Ms. Henkes then stated there were a couple times she would "pass out for twenty minutes or so" and she "wouldn't call it sleeping" but stated she might have "dozed on and off for a ½ hour or so" the night Resident A fell. Ms. Henkes stated she is aware she is supposed to stay awake but claimed she overworked herself and was tired. Ms. Henkes stated Ms. O'Hara was in the kitchen when Resident A fell and was not sleeping because Ms. O'Hara would never fall asleep while working. Ms. Henkes stated she did hear Ms. O'Hara cry out to her when she needed assistance but did not hear Resident A fall and could not get there until after Ms. O'Hara was there to assist Resident A.

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:	Ms. Henke was not capable of handling an emergency situation because she was asleep during third shift on November 26, 2023 when Resident A fell out of her bed. According to her employee record, Ms. Henkes has also received a verbal and written reprimand for sleeping during her shift in September 2023. The residents at the facility require direct care staff members be awake during all shifts to assure their needs are met. This did not occur due to Ms. Henkes sleeping or dozing while she was on shift rather than assisting with monitoring residents and attending to their care.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change in the license status.

Jennifer Browning _____01/04/2023_____
Jennifer Browning Date
Licensing Consultant

Approved By:
Dawn Timm 01/12/2024
_____
Dawn N. Timm Date
Area Manager