GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 18, 2024

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

RE: License #:	AS090395688
Investigation #:	2024A0123023 Rose Home

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 (989) 643-7960.

Sincerely,

Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS090395688
Investigation #:	2024A0123023
Complaint Receipt Date:	02/13/2024
Investigation Initiation Date:	02/15/2024
Report Due Date:	04/13/2024
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:	Rose Home
Facility Address:	308 Ireland Auburn, MI 48611
Facility Telephone #:	(989) 662-4595
Original Issuance Date:	10/01/2018
License Status:	REGULAR
Effective Date:	04/01/2023
Expiration Date:	03/31/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A's weight was 110 lbs. in December 2023. Resident A's weight was 82 lbs. on 01/26/2024. Staff did not report the weight loss to the physician, case manager, or residential nurse. Staff have not been following through with the nurse's care plan that was implemented on 01/26/2024.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/13/2024	Special Investigation Intake 2024A0123023
02/15/2024	Special Investigation Initiated - Letter
02/15/2024	APS Referral APS referral completed.
02/16/2024	Inspection Completed On-site I conducted an unannounced on-site with recipient rights investigator Melissa Prusi.
02/16/2024	Contact - Telephone call made I spoke with Bay Arenac Behavioral Health nurse Barb Guerin, RN.
03/11/2024	Contact - Telephone call made I spoke with Bay Arenac Behavioral Health case manager Amy Ricker via phone.
03/13/2024	Contact- Telephone call made I interviewed home manager Shannon Rivera.
03/14/2024	Contact- Document Received I received requested documentation from the facility.
03/15/2024	Exit Conference I spoke with designated person/administrator Tammy Unger via phone.

ALLEGATION: Resident A's weight was 110 lbs. in December 2023. Resident A's weight was 82 lbs. on 01/26/2024. Staff did not report the weight loss to the physician, case manager, or residential nurse. Staff have not been following through with the nurse's care plan that was implemented on 01/26/2024.

INVESTIGATION: On 02/16/2024, I conducted an unannounced on-site visit with recipient rights investigator Melissa Prusi at the facility.

During this on-site, I observed Resident A. She appeared clean and appropriately dressed. She was observed in the living room area asleep, as well as at the kitchen table eating lunch during this on-site. Resident A is non-verbal and could not be interviewed. She physically appeared visibly very thin in her face and legs.

During this on-site, I spoke with Bay Arenac Behavioral Health dietician Kathy White. She stated that she was not informed of the weight loss for Resident A. She stated that the weights are off but does not know under which conditions each resident is weighed (i.e. wearing a wet brief, etc.) She stated that Resident A is the only resident who has had a consistent decline in weight.

During this on-site I obtained a copy of the *Bay Arenac Behavioral Health Authority's (BABHA) Nursing Guidelines*, as well as Resident A's weight records, *BABHA Nursing Care Plan*, BABHA *Plan of Service*, *Assessment Plan for AFC Residents*, *BABHA Nutritional Assessment and Nutrition Care Plan*.

Resident A's *Nutritional Assessment* written by Kathy White, RDN, dated 03/22/2023 states under *Recommendations/Goals "3. Keep her weight stable at 98# -105# pounds."* The assessment also indicates that Resident A is on a 1,500-calorie diet.

Resident A's BABHA *Nutrition Care Plan* revised 06/27/2023 states that Resident A will maintain a weight between 98 and 105 lbs. Resident A is to have a supplement if Resident A's weight falls below 90 lbs. It also notes to "*Contact RD* (registered dietician) *for any weight loss below 95#."*

Resident A's Plan of Service dated 06/27/2023 states, "*She has lost weight recently, but we are unsure about the accuracy of the weights taken due to scale issues, staff turnover, etc. [Resident A's] RN has asked for all residents to be taken to Madison Clinic for accurate weight on their scale. [Resident A's] weight is determined to be most healthy in the 98–105-pound range. Current weight was reported to be 96 pounds*." The plan also states that *"[Resident A] with support from her home staff will follow the guidelines set by the RD daily to maintain a healthy weight, prevent choking, and have 1:1 supervision during meals, as outlined in the RD plan for the entire PCP year."*

Resident A's *Assessment Plan for AFC Residents dated* 04/13/2023 indicates that Resident A is non-verbal and needs full assistance with communicating needs. For eating, it notes that "*staff will prompt and encourage to feed [Resident A]*." Resident

A is on a pureed diet. The assessment plan does not note any specific caloric diet. A copy of Resident A's *Health Care Appraisal* dated 02/10/2023 notes that Resident A is on a 1800-2000 cal/day diet. Resident A's weight at the time of the appraisal was unable to be assessed due to Resident A being in a wheelchair.

Resident A's weight records were obtained from August 2022 through February 2024. On 12/16/2023, Resident A's weight was recorded as 103 lbs. On 12/23/2023, Resident A's weight was recorded as 77 lbs. On 12/30/2023, Resident A's weight was recorded as 105 lbs., and on 01/06/2024, it was recorded as 89 lbs. On 01/27/2024, it was 88 lbs., and on 2/10/2024, it was recorded as 73 lbs.

On 02/16/2024, I made a call to Barb Guerin, RN. Nurse Guerin stated that yesterday the weight scale was removed from the home, as the scale was never calibrated. Nurse Guerin stated that case manager Amy Ricker sent her an email regarding concerns over Resident A's drastic weight loss. Nurse Guerin stated that she conducted an on-site at the facility and could not find any weight documentation. Staff/home manager Shannon Rivera could not find it, then later sent documentation from the computer. Nurse Guerin stated that there was several times in Resident A's weight record that there was substantial weight loss. She stated that Resident A is tiny, but staff claims that Resident A eats every meal. Staff started using the weight scale at another facility. Nurse Guerin stated that she asked Staff Rivera if the scales had been worked on or calibrated, and if they checked after getting wacky weights. She stated that Staff Rivera said that she called someone named Eric Strode who had been out to recalibrate a scale about six months ago. Nurse Guerin stated that she called Eric Strode to confirm, and he reported to Nurse Guerin that he does not recalibrate scales, has no ability or knowledge to repair scales, and was only at the facility to fix a strobe light. Nurse Guerin stated that Resident A's current weight is about 84 or 85 lbs. per the scale at a different facility. Nurse Guerin stated that there has been no significant weight loss for the other residents in the home, but she is not sure if there is any consistency with how staff are weighing the residents.

On 03/11/2024, I spoke with Resident A's case manager Amy Ricker via phone. Amy Ricker is Resident A's Bay Arenac Behavioral Health case manager. She stated that she discovered Resident A's weight loss during a telehealth meeting with the facility and Resident A. She stated that she was told that Resident A's weight at the time was about 81 or 82 lbs. Resident A's weight the prior month was recorded as 110 lbs. Amy Ricker stated that home manager Shannon Rivera did not alert anyone and did not appear to be alarmed by the weight records. Staff at that time had done nothing to intervene in the weight loss for Resident A. She stated that she told the facility to contact the physician and the nurse immediately. It was determined that the weight scales were not working properly, but there are new scales in the home now. There was a meeting last week to address all of the ongoing issues in the home, and Resident A is slowly gaining weight back. Amy Ricker stated that she does not understand how a resident can drop 30 lbs. and no one notices or expresses any concern. The 110 lb. reading may have been inaccurate, but that is what was documented.

On 03/13/2024, I interviewed home manager Shannon Rivera via phone. She stated that she started as home manager in November 2023. Staff Rivera stated that there was an issue with the scales and the home's nurse had them obtain weights at another facility. The scales are now currently fixed. She stated that they did not know who to call at first about getting the scales fixed. Staff Rivera stated that Resident A is now gaining weight back, Resident A's care plan was updated, and it is unknown why Resident A lost weight. When asked who is responsible for reviewing care plans with staff, she stated that the home manager is. Staff Rivera stated that she was checking weights once per month, but it was assistant home manager Amanda Black who reported a weight change to Barb Guerin, RN once. Staff Rivera then stated that when Resident A weighed in at 84 lbs. in January is when Staff Black said something about it. When asked about the timeframe Staff Black reported it, Staff Rivera did not know. Staff Rivera stated that other staff did not alert her to any issues with the weights. Staff Rivera stated that Resident A's weights were completed on 02/04/2024 at another facility and on the Arjo Lift Resident A's weight was 81 lbs. and on the floor scale it was 73 lbs. Staff Rivera stated that the nurse told her to get Resident A to the doctor to get blood work done. Staff Rivera stated that staff had been giving Resident A seconds during mealtimes, and staff would sit with Resident A and feed Resident A. There were times Resident A would refuse to feed independently and would eat for staff only sometimes. During this phone call, I asked for copies of Resident A's *Residential Progress Notes* due to Staff Rivera stating that staff documented when Resident A received supplemental nutritional drinks.

On 03/14/2024, I received *Residential Progress Notes* for 12/21/2023 through 02/01/2024. The only date that staff noted that Resident A received a supplemental Ensure drink was on 02/01/2024. There were no notes from staff regarding any weight loss concerns, and no mention of supplements provided on the other days. Staff did note that Resident A consumed most of the meals provided during that time frame.

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: **(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:	On 02/16/2024, I conducted an unannounced on-site at this facility. I observed Resident A to be clean and appropriately dressed, but also appeared visibly thin. Resident A was not

	interviewed due to being non-verbal. Dietitian Kathy White was interviewed and reported that Resident A is the only resident who has consistently decline in weight, and the decrease in weight was not reported. Several different documents regarding Resident A's care plan was reviewed, as well as weight records. Per Resident A's care plans, staff are to report to the dietitian if Resident A's weight falls below 95 lbs. Per Resident A's weight records, Resident A's weight was recorded as 77 lbs. on 12/23/2023, 89 lbs. on 01/06/2024, 88 lbs. on 01/27/2024, and 73 lbs. on 02/10/2024. On 02/16/2024, I spoke with Barb Guerin, RN reported she received an email from case manager Amy Ricker alerting her of the weight loss. On 03/11/2024, I spoke with case manager Amy Ricker who reported discovering the weight loss during a telehealth meeting, and Resident A's weight at the time was 81 or 82 lbs. She stated that home manager Shannon Rivera did not notify anyone of the weight loss, and staff at that time had not done anything to intervene with the weight loss. On 03/13/2024, I interviewed home manager Shannon Rivera. She stated that the cause of the weight loss was unknown. She stated that she only checked weights once per month, but that assistant home manager Amy Black reported the weight loss once to Nurse Guerin. She also stated that the staff doing the weights did not report to Staff Rivera about the weight loss. There is a preponderance of evidence to substantiate a rule violation. Resident A experienced significant weight loss. This weight loss was not reported timely to the registered dietician per Resident A's nutrition care plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 02/16/2024, I conducted an unannounced on-site visit with recipient rights investigator Melissa Prusi at the facility. Melissa Prusi stated that Bay Arenac Behavioral Health nurse Barb Guerin, RN has knowledge of a fall Resident B

recently had. Resident B had a “goose egg” bump on the back of the head that was never reported to Nurse Guerin, and staff did not follow the nursing protocols. Staff did not do an incident report for the fall, and the nurse had to fill one out the following day.

During this on-site, Resident B was interviewed. Resident B stated that she cannot remember where Resident B fell, but that Resident B has a bump that was sore and hard on the right back lower side of the head. Resident B reported not being sure who helped Resident B off the floor. Staff Lisa Corrion may have assisted Resident B off the floor, but Resident B cannot remember. Resident B stated that receiving a PRN for pain after the fall. Resident B reported experiencing migraines after falls. Resident B reported feeling dizzy and informed staff of this both before and after the fall. Resident B stated that wanting to get Resident B’s head checked out. Resident B reported not remembering staff checking Resident B over or making any calls after the fall. Resident B stated that a nurse came out and assessed Resident B’s head. Resident B stated that their head was really red, and a staff person asked Resident B if Resident B wanted a head assessment done.

Staff Lisa Corrion was interviewed. Staff Corrion stated that she did start a head assessment form and left it for third shift to continue filling out. She stated that she was in the kitchen at the refrigerator and heard Resident C yell. Resident B had fallen and was sitting on Resident B’s buttocks on the floor. Staff Chrissy Salo assisted Staff Corrion with getting Resident B up. Staff Corrion stated that she assumed Resident B tripped over Resident B’s pants, causing the fall. Staff Corrion stated that Resident B was taken to the kitchen table, and Resident B sat there for a long time afterwards, then Resident B was taken to the bedroom to sit in Resident B’s recliner chair. Staff Corrion stated that Resident B did not complain of any pain, and that Resident B falls all the time.

During this on-site I obtained a copy of the *Bay Arenac Behavioral Health Authority’s Nursing Guidelines* from Melissa Prusi. *Bay Arenac Behavioral Health Authority Policies and Procedures Manual Nursing Guidelines* states that staff are supposed to call the home nurse or on call nurse and home manager with all falls. Staff are to complete a *Head Injury Assessment* form for unwitnessed falls, or if the individual reportedly hit their head. An incident report has to be completed, and if appropriate, 911 would need to be called.

During this on-site, I observed an A*FC Licensing Division- Incident/Accident Report* dated 02/11/2024 at 10:57 am authored by staff Lisa Corrion. It stated in summary that Resident B had been sleeping at the table. Staff tried to wake Resident B multiple times, and Resident B would not move from the table for safety. Resident B woke up, started utilizing their walker, then tripped on their own pajama pants. It states that Resident B fell on their bottom and did not hit their head. Staff assisted Resident B with getting up, escorted Resident B to their bedroom, and Resident B sat in their recliner. It states staff checked on Resident B several times, and Resident B reported being fine.

It should be noted that there were no corrective measures documented, and there were no names noted in the *Person(s) Notified* section of the incident report.

During this on-site, I observed a note in the staff communicator logbook dated 01/15/2024 that states "*When someone falls fill out the fall report sheeting hanging in the med room*."

A copy of Resident B's *BABH's Nursing Care Plan- Fall Prevention Guidelines for [Resident B]* authored by Barb Guerin*, RN and* dated 01/23/2024 states the following:

- *Staff will monitor for and remove items from [Resident B'] path while walking that present a Fall Hazard.*
- *Assure [Resident B's] pants fit properly and that [Resident B] is not stepping on bottom of pant legs. Assure proper fitting shoes are worn.*
- *Staff will complete an IR for all falls- be sure to document location of fall and complete body check documenting any injuries. Notify nurse of all falls. Head Injury Assessment to be completed for any unwitnessed fall and falls if [Resident B] hits [Resident B's] head.*

On 02/16/2024, I made a call to Barb Guerin, RN. She stated that home manager Shannan Rivera told Nurse Guerin that they don't need to make any calls for falls unless a resident hits their head. Staff Rivera could not say what the guidelines for falls stated. Nurse Guerin stated that every fall is supposed to be reported to the nurse. Any unwitnessed falls require a call to the nurse, an incident report, head assessment, and follow any instructions the nurse provides.

A copy of an attachment to an incident report dated 02/14/2024 written by Nurse Guerin in summary states that she visited the home 02/12/2024, was informed Resident B had a fall on 02/11/2024 that was not reported to nursing, observed a head injury assessment that did not begin until 9:15 am on 02/12/2024, and that Resident B had an injury (i.e. lump on the back of the head). Resident B was assessed by Nurse Guerin, and staff were provided with instructions.

On 03/11/2024, I spoke with Resident B's case manager Amy Ricker via phone. She stated that an incident report was written after the fact noting that Resident B did not a head assessment because Resident B did not hit their head. She stated that they went over the policy regarding unwitnessed falls.

On 03/14/2024, I received a copy of Resident B's *Head Injury Assessment Record*. It is dated 02/12/2024 and the assessment appears to have begun at 9:15 am and ended at 8:00 pm on 02/12/2024.

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: **(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:	On 02/16/2024, I was informed by recipient rights investigator Melissa Prusi that Resident B had an unwitnessed fall on 02/11/2024 that was not reported to the home's nurse, and staff did not follow protocol. Resident B was interviewed and reported having a fall that resulted in a bump on the back of the head. Staff Lisa Corrion was interviewed and reported starting a head assessment. Bay Arenac Behavioral Health Nursing Guidelines state that staff are to notify nurses regarding all falls and complete a head injury assessment for unwitnessed falls. An incident report completed by Staff Corrion dated 02/11/2024 at 10:57 am notes that Resident A had a fall but did not hit their head. The incident report does not note that anyone was contacted about the fall, and no corrective measures were documented. The staff communicator log was observed to have an entry dated 01/15/2024 that says that when a resident falls, staff have to fill out a fall report sheet. Resident B's *Nursing Care Plan* was reviewed, and states that staff are to notify nurse of all falls and complete a head injury assessment. Nurse Barb Guerin was interviewed and reported that she was not notified of the fall, but found out about it a day later, and the head injury assessment was not started until 02/12/2024 at 9:15 am. A copy of the head injury assessment form was obtained and confirms the assessment did not begin until the following day after the fall.

	Case manager Amy Ricker stated that an incident report was completed after the fact noting that a head injury assessment was not completed because Resident A did not hit their head. There is a preponderance of evidence to substantiate a rule violation due to staff not adhering to Resident A's nursing care plan, nor BABH's fall policy.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 03/15/2024, I conducted an exit conference with designated person and administrator Tammy Unger. I informed her of the findings and conclusions.

IV. RECOMMENDATION

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

03/18/2024

Shamidah Wyden Date
Licensing Consultant

Approved By:

03/18/2024

Mary E. Holton Date
Area Manager