GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 19, 2024

Karen LaFave
Adult Learning Systems - UP, Inc
Suite-4
228 West Washington
Marquette, MI 49855

RE: License #: AS520315853
Investigation #: 2024A0873009
Cedar Hills

Dear Ms. LaFave:

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.

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 #:	AS520315853
Investigation #:	2024A0873009
Complaint Receipt Date:	01/25/2024
Investigation Initiation Date:	01/25/2024
Report Due Date:	03/25/2024
Licensee Name:	Adult Learning Systems - UP, Inc
Licensee Address:	Suite-4 228 West Washington Marquette, MI 49855
Licensee Telephone #:	(906) 228-7370
Administrator:	Karen LaFave
Licensee Designee:	Karen LaFave
Name of Facility:	Cedar Hills
Facility Address:	1560 Cypress Street Ishpeming, MI 49849
Facility Telephone #:	(906) 486-4065
Original Issuance Date:	11/18/2011
License Status:	REGULAR
Effective Date:	04/20/2022
Expiration Date:	04/19/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff did not immediately seek emergency care for Resident A	Yes
Additional Findings	No

III. METHODOLOGY

01/25/2024	Special Investigation Intake 2024A0873009
01/25/2024	Special Investigation Initiated - Telephone Interview with ORR-Pathways
01/25/2024	Inspection Completed On-site
01/25/2024	Contact - Face to Face Staff Interviews
01/26/2024	Contact – Telephone call received Interview with ORR
01/26/2024	APS Referral Referred to APS
01/29/2024	Contact - Face to Face Staff interviews at ALS
02/05/2024	Contact - Face to Face Staff interviews at ALS
02/05/2024	Inspection Completed-BCAL Sub. Compliance
02/05/2024	Exit Conference With Karen LaFave

ALLEGATION:

Staff did not immediately seek emergency care for Resident A.

INVESTIGATION:

On 1/24/24, I received a phone call from Casey O'Connor, officer of recipient rights at Pathways community mental health. Ms. O'Connor reported to me that Resident A had a stroke and was currently hospitalized. I was told that Resident A became unresponsive up to a full 24 hours before staff sought emergency care.

On 1/25/24, I interviewed home manager Becky Prisk-Pittsley at Adult Learning Systems (ALS) office. Ms. Prisk-Pittsley reported that Resident A had been declining for several weeks leading up to her hospitalization and provided a timeline. She stated that on 1/12/24, Resident A had declined enough that staff felt it appropriate to have Resident A taken to the hospital. Resident A had begun to have trouble walking, dressing, and performing ADLs on her own. At the hospital, Resident A was given an x-ray of her chest and shoulder and diagnosed with a urinary tract infection and prescribed an antibiotic. She further stated that on 1/16/24, Resident A began improving even though she was still having trouble speaking. On 1/19/24, Resident A was taken to her primary care physician but the doctor could find nothing wrong. On 1/23/24, when Ms. Prisk-Pittsley arrived at the home for her morning shift, the midnight shift reported to her that Resident A refused to get out of bed for her usual, two-time-a-night, toileting. During that morning shift Resident A refused to get out of bed, although she was soaked with urine. A second staff member was successful in getting Resident A out of bed and into a shower chair so staff could wash her. Later that morning Resident A was brought to the kitchen table where she partially ate a breakfast of eggs and toast, with assistance. Resident A could not eat on her own and did not socialize with other residents, which is unusual for her. Staff took Resident A's vitals and called Kelsey Williams, Adult Learning Systems' area director, to report that they were normal. Ms. Prisk-Pittsley reports she was told by Ms. Williams to monitor Resident A for 24 hours. During the rest of her shift, Resident A's condition remained unchanged and she informed staff at the next shift change to continue monitoring her. The next morning, 1/24/24, at the beginning of Ms. Prisk-Pittsley's shift, midnight shift reported to her that Resident A was, again, completely unresponsive through the night. Ms. Prisk-Pittsley, along with staff member Angela Roat, noticed there was no response from Resident A and contacted EMS to transport her to the hospital.

On 1/25/24, I interviewed assistant home manager Angela Roat at ALS. Ms. Roat provided a timeline and reported that around 1/1/24, staff began noticing Resident A's condition change. Symptoms included her reporting she did not feel well, her ribs reportedly sore, a change in her gait, and a decrease in leg movement. She stated that on 1/11/24, Resident A refused a resident outing, which was very unusual for her, opting instead to just lay on the couch. On 1/14/24, Ms. Roat became concerned with Resident A's deteriorating condition and reports that, although she

expressed her concerns to Ms. Prisk-Pittsley, she was told that Resident A was fine and there was nothing to be worried about. On 1/19/24, Ms. Roat took Resident A to her primary care physician for an appointment at which Resident A presented with “duck-lips,” was unusually quiet, and had a left hand that was involuntarily shaking. After this appointment Ms. Roat purchased McDonalds for Resident A which she refused to eat. On 1/23/24, when Ms. Roat came in for her morning shift, she was told by the midnight shift that Resident A was completely unresponsive through the night. Ms. Roat assessed Resident A and found her to be soaked through with sweat and urine. Ms. Roat got her out of bed and into the shower to clean her. Ms. Roat was told by management to continue to monitor Resident A. By the afternoon, Resident A had vomited on herself and at lunch was unresponsive. Staff attempted to move Resident A’s limbs and felt slight resistance. By 1pm, when staff attempted to move Resident A to the toilet, they noted that she was “dead-weight.” Ms. Roat reports staff were uncomfortable with the situation and agreed they felt Resident A was dying. Ms. Roat came back to work for her morning shift the day of 1/24/24, was told by midnight shift that, again, Resident A was unresponsive. Staff called EMS who arrived at 7:30am and took Resident A to the hospital.

On 1/26/24, I received call from Ms. O’Connor who reported to me that Resident A died at the hospital. I called in a referral to adult protective services.

On 1/29/24, I interviewed staff member Wendy Stone at ALS. Ms. Stone reiterated a similar timeline for Resident A as well as similar symptoms as Ms. Rout. Ms. Stone reported that, although she wanted to call 911 and have Resident A taken the hospital, she was told not to by Ms. Prisk-Pittsley, and told staff were only to monitor her. Ms. Stone felt that if she called 911 her job would be in danger.

On 1/29/24, I interviewed staff member Dessa Lalonde at ALS. Ms. Lalonde reiterated a similar timeline and symptoms for Resident A as Ms. Rout and Ms. Stone. Ms. Lalonde reported that she feels guilty for not calling 911 and would have if she had not received instructions from Ms. Prisk-Pittsley to continue to monitor Resident A rather than call 911.

On 1/29/24, I interviewed Adult Learning Systems area director Kelsey Williams at ALS. She stated that her role was to directly oversee Cedar Hills and other homes. Ms. Williams reported that she was aware of Resident A’s condition and told Ms. Prisk-Pittsley, on the morning of 1/23/24, to continue to monitor Resident A’s condition and contact her if anything changes. Ms. Williams reports that she only received one call from the home that morning and that, if the home had contacted her at any other time later in the day to report to her Resident A’s deteriorated condition, she would have urged staff to call 911. Ms. Williams reports that she is confused as to why staff would not have called 911 if so many of them were as concerned as they were about Resident A’s condition.

On 2/5/24, I interviewed Ms. Prisk-Pittsley for a second time. Ms. Prisk-Pittsley stated she made two calls the day of 1/23/24; one to Ms. Williams and the other to

Resident A's primary care physician. Ms. Prisk-Pittsley was unable to get ahold of anyone at the physician's office and left a voicemail but they never called back. Ms. Prisk-Pittsley never told staff to not call 911 and has always stressed to staff that it is okay to call 911 if they feel it is warranted. Ms. Prisk-Pittsley was told by Ms. Williams to call her with any updates but she did not because she did not feel there was enough of a change in Resident A's condition to call with an update. Ms. Prisk-Pittsley felt that, because no health care professional who assessed Resident A felt concerned about her condition, Resident A's symptoms must have been behavioral. Ms. Prisk-Pittsley feels the entire health system failed Resident A.

On 2/5/24, I interviewed Cole Lindberg at ALS. Mr. Lindberg reported that he does not understand why, if so many staff were as concerned as they seemed, no one called 911. Mr. Lindberg showed me a copy of Adult Learning Systems' "Medical Emergency Procedure" form which all staff are required to sign as part of their training. The form explains what to do in cases of medical emergencies and makes it clear that staff are not to contact management before calling 911. Staff are required to handle the emergency on their own, without concern for what their manager may think.

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:	Resident A began experiencing unusual physical and psychological symptoms beginning in early January. Her conditioned worsened to the point that she became almost completely unresponsive on the night of 1/22/24 and into the morning hours of 1/23/24. However, although several staff reported that they felt they should have called 911, no one did until the morning of 1/24/24.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 2/5/24, I shared the findings of this report with licensee designee Karen LaFave at ALS offices. There were some concerns and discussion about what more management could do to help direct care staff more fully understand that they never need to contact their immediate supervisors, or wait for those supervisors to give them permission, to contact emergency services. Ms. LaFave agreed that they would consider further options as part of developing the corrective action plan.

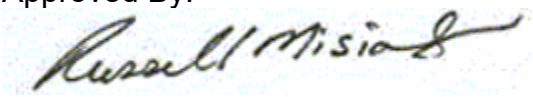
IV. RECOMMENDATION

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

3/13/24

Garrett Peters — Date
Licensing Consultant

Approved By:



3/14/24

Russell B. Misiak — Date
Area Manager