STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR

May 29, 2024

Timothy Adams
Braintree Management, Inc.
7280 Belding Rd. NE
Rockford, MI 49341

RE: License #: AL340338193
Investigation #: 2024A0622021
Harrison House AFC

Dear Mr. Adams:

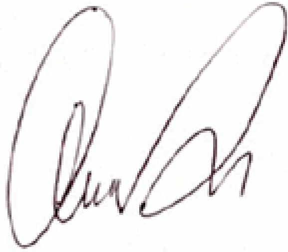
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 284-9727.

Sincerely,



Amanda Blasius, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL340338193
Investigation #:	2024A0622021
Complaint Receipt Date:	04/08/2024
Investigation Initiation Date:	04/09/2024
Report Due Date:	06/07/2024
Licensee Name:	Braintree Management, Inc.
Licensee Address:	7280 Belding Rd. NE Rockford, MI 49341
Licensee Telephone #:	(616) 813-5471
Administrator:	Jessica Adams
Licensee Designee:	Timothy Adams
Name of Facility:	Harrison House AFC
Facility Address:	532 Harrison Avenue Belding, MI 48809
Facility Telephone #:	(616) 244-3443
Original Issuance Date:	04/02/2013
License Status:	REGULAR
Effective Date:	10/01/2023
Expiration Date:	09/30/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A fell down the stairs and sustained multiple injuries. Resident A was recently moved to the second floor after requesting to stay on the first floor.	Yes

III. METHODOLOGY

04/08/2024	Special Investigation Intake 2024A0622021
04/09/2024	Special Investigation Initiated - Phone call with case manager, Kayla Mobley
04/12/2024	Inspection Completed-BCAL Sub. Compliance
04/25/2024	Phone call to guardian, Joanna Hillard
05/02/2024	Email to Jessica Adams and Desire Wyatt
05/06/2024	Documentation received from Desire Wyatt
05/29/2024	Phone interviews with direct care workers, Haley Clark and Audrey Bishop.
05/30/2024	Exit Conference and interview with Jessica Adams, administrator

ALLEGATION: Resident A fell down the stairs and sustained multiple injuries. Resident A was recently moved to the second floor after requesting to stay on the first floor.

INVESTIGATION:
On 04/08/2024, I received this complaint through the Bureau of Community and Health Systems online complaint system. According to the complaint, Resident A fell down the stairs and sustained multiple injuries. Resident A was recently moved to the second floor despite recommendations from her case worker and guardian that she remain on the first floor. Resident A also reported that no one answers her call lights since moving to the second floor.

On 04/09/2024, I interviewed Kayla Mobley via phone. Ms. Mobley is Resident A's community mental health case manager. Ms. Mobley stated that she is a new case manager for Resident A, but she was informed from Resident A that she fell down the stairs and had to go to the hospital. Ms. Mobley reported Resident A was recently moved to the second floor of the AFC home. Ms. Mobley stated that a meeting occurred in the past with a previous AFC home manager, Blake Burns,

regarding Resident A moving to the second floor and the final decision was made to not move Resident A to the second floor. Ms. Mobley reported that once a new AFC home manager, direct care worker (DCW) Desire Wyatt started at the AFC the conversations started again to move Resident A to the second floor. Ms. Mobley explained that she shared her concerns with DCW Desire Wyatt and administrator Jessica Adams regarding Resident A moving to the second floor of the home due to her limited mobility. Ms. Mobley also reported that Resident A's guardian had concerns regarding Resident A moving to the second floor. Although concerns regarding Resident A moving to the second floor were shared, Resident A was moved to the second floor according to Ms. Mobley. It was reported to Ms. Mobley that Harrison House AFC agreed to help Resident A with going down up and down the stairs and she was provided with a call light that she was supposed to push when needing assistance. Ms. Mobley explained direct care staff were not answering her call light every time and it was not realistic for Resident A to wait for direct care staff to answer her call light to go down the stairs. Ms. Mobley reported that on 04/02/2024, Resident A fell down the stairs and sustained multiple injuries. She was taken to the hospital and returned to the AFC later that night. Ms. Mobley explained that Resident A is still located on the second floor although she recently fell down the stairs.

On 04/12/2024, I completed an unannounced onsite investigation to Harrison House AFC. During the onsite investigation, I reviewed Resident A's resident record, interviewed manager, Desire Wyatt and Resident A.

On 04/12/2024, I interviewed DCW Desire Wyatt who reported that Resident A fell down the stairs about three or four days after she was moved to the second floor. DCW Wyatt reported that she had verbal direction from the doctor that she could move to the second floor. DCW Wyatt explained that Resident A was sent back to the hospital because her leg looked infected after her fall. DCW Wyatt stated her previous first floor bedroom is no longer available, as it has been filled by a new resident. DCW Wyatt showed me the on-call alarm, which was in the office. She stated that she often puts it in the kitchen area when she is not in the office. DCW Wyatt reported that she feels that staff answer the call light in an appropriate timeframe.

On 04/12/2024, I interviewed Resident A in person in her bedroom on the second floor. She reported that she had some hangers that she wanted to bring back downstairs and had been waiting for direct care staff to assist her. Resident A reported direct care staff don't always answer her call light, therefore she decided to take the hangers downstairs herself. Resident A explained that she was taking the staircase near the kitchen and when she was about halfway down, she fell, flipped and landed on her back. Resident A broke her pinky, had a large knot on her head, and infection and swelling in her leg. Resident A explained that she did not want to move upstairs, and her guardian and case worker did not want her to move upstairs due to being a high fall risk. Resident A stated that the owner of Harrison House called her and stated the following: "If you move upstairs, I'll pay for your cable."

Resident A explained that it was hard to say no, to having free cable, therefore she agreed to move upstairs. Resident A stated that she prefers to move back downstairs, as it is safer and she does not need to use her call light for help downstairs. Since she fell, direct care staff has asked her to use the other set of stairs as they are not as steep and also wait for staff to assist her up and down the stairs.

On 04/12/2024, I reviewed documentation that was available within the file. According to her *AFC Resident Information and Identification Card,* Resident A moved into Harrison House AFC on 08/17/2020. It was reported that Resident A has always occupied a bedroom on the first floor until she was recently moved to the second floor in March 2024.

An incident report from 04/02/2024 was reviewed and documented the following:

"Client was carrying hangers down the steps and mis-stepped and fell down the last five steps. Client hit her head, lacerated her nose, and skinned her knees and shin. Action taken by the staff- ice pack was applied to client's head. Staff assessed the client inquiries. Staff cleaned off client's face. Vitals were taken by staff. Staff called the paramedics.
Prevent recurrence: Staff will remind client to alert staff with her call button if she needs help carrying items up and down the stairs. Staff will ask client during checks if she needs anything carried up or down the stairs. Staff will follow discharge instructions upon return to the facility."

During the unannounced onsite investigation on 04/12/2024, the following healthcare appraisals were available for review:

- *Health care appraisal dated 07/20/2021 and reports that she is fully ambulatory.*
- *Health care appraisal dated 09/26/2022 and box 12 for mobility/ambulatory status is left blank. It is reported on the form that she has poor balance and gait.*

During the unannounced onsite investigation on 04/12/2024, I reviewed Resident A's *Assessment Plan for AFC Residents* dated 01/19/2023, which stated the following:

"Bathing: staff will assist with bathing
Dressing: Staff will assist with any dressing assistance
Use of assistive devices: uses a walker and cane at different times
Special equipment used: walker and cane"

An after-summary visit dated 4/2/2024, was reviewed from Resident A's visit to the hospital. According to the summary, Resident A diagnoses were:
Fall downstairs; initial encounter
Bilateral hand pain
Acute pain of both knees

Contusion of right leg; initial encounter
Forehead contusion; initial encounter
Acute head injury; initial encounter
Acute bilateral back pain; unspecified back location
Closed avulsion fracture of middle phalanx of finger; initial encounter

During the unannounced onsite investigation on 04/12/2024, DCW Wyatt reported that she had paperwork for Resident A completed but not filed yet that she needed to find. I asked DCW Wyatt to send me any paperwork that she had completed via email.

On 05/02/2024, I followed up via email with DCW Wyatt and administrator Jessica Adams regarding the paperwork.

On 05/06/2024 additional documentation was received via email. The following items were received.

- *Health care appraisal dated 01/17/2024 and reports that she uses a walker and has an unstable gait.*
- *Assessment Plan for AFC residents dated 05/02/2024, which documented the following:*

Bathing: staff will assist with bathing
Dressing: Staff will assist with any dressing assistance
Use of assistive devices: uses a walker and cane at different times
Special equipment used: walker and cane.

Documentation from Doctor Sheila Gendich dated 5/2/2024. Resident A is okay to go up and down the stairs using the handrails, not carrying things.

On 05/29/2024, I interviewed direct care worker, Audrey Bishop via phone. DCW Bishop is the live in staff at Harrison House AFC. She reported that when Resident A moved to the second floor, she recalled answering many of her call lights. She reported that staff would not dismiss a call light. DCW Bishop reported that staff usually respond to a call light within one to two minutes. DCW Bishop reported that the call light alarm can be moved from the office, kitchen, or other centralized location, so staff can hear them go off.

On 05/29/2024, I interviewed direct care worker, Haley Clark via phone. DCW Clark stated that she works first shift during the week. DCW Clark explained that they have an older call light machine and its mainly kept in the kitchen. DCW Clark explained that she remembers responding to Resident A when she first moved upstairs and also observing other staff respond to Resident A’s call light. DCW Clark reported that Resident A currently does not use her call light often, as she spends a lot of her time out of the facility or on the main floor.

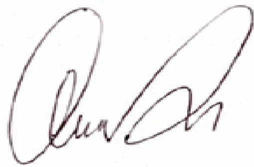
On 05/30/2024, I interviewed administrator, Jessica Adams via phone. She reported that Resident A was willing to move upstairs and she offered to pay for her cable if

she moved upstairs. Administrator Jessica Adams reports that they have a verbal confirmation from Resident A's physician, that she was approved to move upstairs.

APPLICABLE RULE	
R 400.15408	**Bedrooms generally.**
	(9) A resident who has impaired mobility shall not sleep in or be assigned a bedroom that is located above the street floor of the home.
ANALYSIS:	Based on interviews completed and documentation reviewed, it was determined that Resident A has impaired mobility due to using a walker and cane, therefore should not be sleeping or assigned a resident bedroom on the second floor of the facility. Resident A's guardian and mental health care worker discussed their concerns with administrator Jessica Adams regarding Resident A's impaired mobility and their desire to keep Resident A on the first floor. Despite these concerns, Resident A's expressed desire to remain in her first floor bedroom, and Resident A's documented mobility challenges of unstable gait and use of a walker and cane to assist with mobility, Resident A was moved to the second floor on 04/01/2024. On 4/2/2024 Resident A fell down the stairs leading to multiple injuries as documented by the after-visit summary from her hospital visit on 4/2/2024. Although documentation was received from Resident A's physician Dr. Gendich stating Resident A is capable of going up and down stairs without carrying items, it was dated after her move to the second floor and after her fall down the stairs. An updated health appraisal was not completed before her move to the second floor confirming that Resident A no longer uses a walker or cane or now has a stable gait, therefore a violation was established due to her limited mobility.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

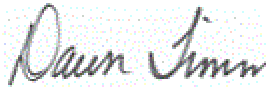
Contingent upon receipt of an acceptable corrective action plan, I recommend that the status of the license remains the same.



05/15/2024

Amanda Blasius Date
Licensing Consultant

Approved By:



05/31/2024

Dawn N. Timm Date
Area Manager