GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 30, 2024

Neiman Byerly
Byerly Enterprises, LLC
4759 Owasco Ct.
Clarkston, MI 48348

RE: License #: AM630397532
Investigation #: 2024A0605021
Hidden Acres Manor

Dear Neiman Byerly:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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 (248) 975-5053.

Sincerely,

Frodet Dawisha

Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
3026 W. Grand Blvd
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM630397532
Investigation #:	2024A0605021
Complaint Receipt Date:	03/15/2024
Investigation Initiation Date:	03/18/2024
Report Due Date:	05/14/2024
Licensee Name:	Byerly Enterprises, LLC
Licensee Address:	4759 Owasco Ct. Clarkston, MI 48348
Licensee Telephone #:	(810) 691-6400
Administrator/Licensee Designee:	Neiman Byerly
Name of Facility:	Hidden Acres Manor
Facility Address:	8616 Hidden Acre Court Clarkston, MI 48348
Facility Telephone #:	(248) 241-6507
Original Issuance Date:	08/07/2019
License Status:	1ST PROVISIONAL
Effective Date:	01/22/2024
Expiration Date:	07/21/2024
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL/AGED

II. ALLEGATION(S)

	Violation Established?
On 03/08/2024, Resident A was admitted to the hospital malnourished with multiple sores. Resident A had pressure ulcers on his back and bottom and multiple infections from the wounds. In July 2023, Hidden Acres Manor gave Resident A's mother/guardian a 30-day notice, stated they could no longer care for him.	Yes

III. METHODOLOGY

03/15/2024	Special Investigation Intake 2024A0605021
03/18/2024	Special Investigation Initiated – Letter Email sent to Adult Protective Services (APS) worker Carmen Smith who is assigned this investigation
03/18/2024	APS Referral Adult Protective Services (APS) made referral
03/18/2024	Contact - Document Received Email from APS worker Carmen Smith
03/18/2024	Contact - Telephone call made Spoke with social worker, Barb at Regency of Waterford regarding Resident A. Attempted to call Resident A's legal guardian. Received recording: Verizon wireless, your call cannot be completed as dialed, please check your number, and dial again.
03/20/2024	Contact - Telephone call made Interviewed registered nurse (RN) case manager (CM) Elaine with McLaren Oakland Hospital regarding Resident A
03/20/2024	Contact - Face to Face Made face-to-face with Resident A at McLaren Oakland Hospital and the RN CM Elaine
03/20/2024	Inspection Completed On-site Conducted unannounced on-site investigation

03/25/2024	Contact - Telephone call received Discussed allegations with Dr. Carl Byerly and his wife Jeanine Byerly
03/28/2024	Contact - Telephone call made Interviewed Elara's Clinical Coordinator, Heather, Katie Smith with Northpointe BFS Office of Recipient Rights, DCS Sherry McLean, assistant HM Savonne Keys, DCS Kiyana Harrison and DCS Tya Vanderson. Left message for DCS Makalyn Caudell.
03/28/2024	Contact - Telephone call made Left message for Resident A's case manager with Northpointe BHS Breanna Allen
04/04/2024	Contact - Telephone call received Discussed allegations with case manager Breanna Allen
04/09/2024	Contact - Telephone call received From Dr. Carl Byerly
04/15/2024	Contact - Document Sent Email to and from Dr. Carl Byerly
05/02/2024	Contact - Telephone call made Left message for Elara HHC occupational therapist (OT) Joan Adams
05/13/2024	Contact – Telephone call made Follow-up with Regency of Waterford
05/20/2024	Exit Conference Left message for licensee designee Neiman Byerly

ALLEGATIONS:

On 03/08/2024, Resident A was admitted to the hospital malnourished with multiple sores. Resident A has pressure ulcers on his back and bottom and multiple infections from the wounds. In July 2023, Hidden Acres Manor gave Resident A's mother/guardian a 30-day notice, stating they could no longer care for him.

INVESTIGATION:

On 03/15/2024, intake #200084 was referred by Adult Protective Services (APS) regarding Resident A was admitted into the hospital on 03/08/2024 malnourished with multiple sores. Resident A had pressure ulcers on his back and bottom. He had multiple infections from the wounds.

NOTE: The complaint was made approximately seven days after Resident A was admitted into the hospital.

On 03/18/2024, an email was sent to APS worker Carmen Smith. Ms. Smith stated she has had this investigation since November 2023 regarding similar allegations pertaining to Resident A. Ms. Smith is still involved in this case because of Resident A's mother who is also the legal guardian. A petition was filed to modify the guardianship due to the mother not paying Hidden Acres Manor Resident A's cost of care. However, Ms. Smith has not, nor will she be investigating these allegations.

On 03/18/2024, I contacted via telephone the social worker, Barb at Regency of Waterford regarding Resident A. Resident A was discharged from the hospital to their facility on 03/16/2024; however, he was still not well so he was returned to the hospital four hours later.

On 03/18/2024, I attempted to call Resident A's legal guardian. Received the following recording: Verizon wireless, your call cannot be completed as dialed, please check your number, and dial again.

On 03/20/2024, I contacted via telephone registered nurse (RN) case manager (CM) Elaine with McLaren Oakland Hospital regarding Resident A. Resident A was admitted into the hospital on 03/08/2024. At admission, he was found malnourished, dehydrated, and with five pages long of wound sores. Resident A also had a blood infection and was in isolation, but not anymore. The wounds were found and noted in the following areas left lateral knee- stage 2, left lateral hip- stage 3, left scapula- stage 1, left big toe- deep tissue injury, left ankle- stage 2, right first toe- stage 2, left shoulder- stage 2, left medial thigh- stage 2, right shoulder- stage 1, and right chest wound but not a pressure sore. The RN CM stated that these pressure sores are a result of malnourishment and Resident A not being repositioned frequently. It is unknown when Resident A will be discharged.

On 03/20/2024, I conducted a face-to-face visit with Resident A at McLaren Oakland Hospital; however, I only observed Resident A sleeping in his room. I also met with the RN CM, Elaine and RN Brandi who was assigned to Resident A. Resident A had been admitted to McLaren Oaklan Hospital in October 2023 for aspiration and dehydration. He weighed 116.8 pounds at that time. The RN CM stated that if Resident A was in the shape he was found on 03/08/2024, Resident A would have never been discharged

then. The RN CM stated that Resident A's mother visited and wanted to take pictures of the wounds, but RN CM refused. The RN CM stated that the hospital did not take any pictures of the wounds at admission because it is their policy for privacy not to take pictures of their patients. The RN CM reached out to her supervisor to find out if she can provide me with documentation to reflect the wounds found at admission, but the supervisor refused to provide me with any documentation.

On 03/20/2024, I conducted an on-site investigation at Hidden Acres Manor. The home manager (HM) Jennifer Stancroff, direct care staff (DCS) Steven Redman and Abby Weidel and compliance officer Simone Lewis were present. Also present were Resident C, Resident D, Resident E, Resident F, and Resident G who was showering during this visit. Resident B was in school.

I interviewed HM Jennifer Stancroff and Simone Lewis regarding the allegations. Resident A moved into Hidden Acres Manor on 12/21/2022. He is autistic with a traumatic brain injury and non-verbal. Resident A was ambulatory and fed himself. He weighed 150 pounds according to the health care appraisal (HCA) completed on 12/20/2022. The HM stated soon after, sometime in January 2023, Resident A's status changed; he was not eating, and staff had to standby and assist with ambulation. He was sent to McLaren Oakland Hospital on 01/17/2023. According to the discharge papers, Resident A was dehydrated, and the discharge plan was to give clear liquids only, a pureed diet, and weekly weights. Resident A was pocketing food, so he was put on a pureed diet according to the HM. Resident A was still declining and went into the hospital again on 04/02/2023-04/11/2023 to Trinity Health. He was seen again for dehydration and electrolyte imbalance. Resident A was discharged back to Hidden Acres Manor with the following discharge instructions, one to one feeding, pureed-honey consistency and high protein pudding three times. HM stated staff was following the discharge instructions and weighing Resident A weekly, but the HM could not locate the documents during this visit. Resident A was hospitalized again from 05/16/2023-05/26/2023 for pneumomediastinum and weakness. He was discharged back to Hidden Acres Manor with a feeding tube and high calorie and high protein diet. HM stated staff followed hospital's discharge plan, but Resident A went back into Trinity Health Hospital on 06/13/2023. He was circumcised and a catheter was put in and he had a wound. He was discharged back to Hidden Acres Manor. He then went back to Trinity Health Hospital from 06/19/2023-06/23/2023, for a urinary tract infection (UTI) due to the catheter. He was discharged back to Hidden Acres Manor with no discharge instructions.

On 06/26/2023, Resident A pulled the peg tube out and went into Trinity Health Hospital. The peg tube was put back in and Resident A was discharged back to Hidden Acres Manor. Again, HM stated that staff were following discharge instructions regarding Resident A's nutrition, but Resident A continued to decline. Resident A's mother/guardian was issued a 30-discharge notice in July 2023, due to Resident A requiring a "higher level of care," than what Hidden Acres Manor could provide. Resident A's case manager was also notified of the discharge and was assisting with locating a nursing home for Resident A. In the meantime, Resident A was hospitalized

again on 08/22/2023 at Trinity Health Hospital regarding the feeding tube and constipation. There were no discharge instructions for this visit. Resident A was hospitalized again on 10/20/2023 at McLaren Clarkston Hospital for aspiration precautions and then from 12/03/2023-12/07/2023 for a UTI at Trinity Health Hospital.

The HM stated that staff were providing Resident A with the care he required even though, Resident A required a higher level of care. Per the HM, staff were following all hospital instructions regarding his nutrition, but he continued to lose weight because he was declining. The case manager, Breanna Allen with Northpoint Behavioral Health Systems (BHS) was actively looking for placement but according to all the hospitals, the HM stated that Resident A was discharged back to Hidden Acres Manor, because "Resident A did not qualify for a nursing home." Resident A continued to go in and out of the hospital. He then returned to Trinity Health Hospital from 01/08/2024-01/10/2024 for a UTI and an indwelling catheter. Elara Home Health Care (HHC) was providing care to Resident A regarding his wound and now the catheter. The registered nurse (RN) Malia was the only person providing catheter care, not staff from Hidden Acres Manor. If anything occurred with the catheter, the RN would be contacted. If the RN could not come out to the home after hours, then Resident A would be sent to the hospital. Resident A was discharged again back home. He went back to Trinity Health Hospital on 01/20/2024 because Resident A was "assaulted," by Resident B (this allegation will be addressed in SIR# 2024A0605025). Resident A was examined and returned to Hidden Acres Manor. Resident A then went back to Trinity Health Hospital on 02/06/2024 for a fever and being lethargic but was discharged again. No discharge instructions were noted. Resident A was sent to McLaren Oakland Hospital on 03/08/2024 by Elara HHC RN, Collette after she visited Resident A at Hidden Acres Manor. Resident A did not return to this group home.

HM provided me with Resident A's assessment plan completed on 12/20/2022. Per the assessment plan, Resident A was feeding himself with staff assistance and was ambulatory. However, the next assessment plan completed on 01/30/2024 had "vegetative state, tube fed, and total care," throughout the assessment plan. There was no updated assessment plan between 12/20/2022 and 12/20/2023 documenting Resident A's decline, his needs, and how staff were meeting those needs. HM stated that about three-four months ago, Resident A became non-ambulatory requiring two-person assist. He was not responding to occupational therapy (OT) in 10/2023. OT was also through Elara HHC. The OT was Joan.

HM provided me with Resident A's HCA for 12/20/2022 and Resident A was "fully ambulatory weighing 150 pounds." I was also provided with HCA for 01/30/2024, that stated, "clean, thin; wheelchair, continue tube feeding per dietician recommendation, weighing 110 pounds."

I also reviewed Resident A's weight records and noted the following: 130 pounds at admission, 01/2023 missing, 02/01/2023 and 03/01/2023 at 125 pounds, 04/18/2023 at 100 pounds (lost 25 pounds - refusing to eat, has been in and out of hospital is noted on weight record), 05/05/2023 at 106 pounds, 06/04/2023 and 07/05/2023 at 107 pounds,

08/02/2023 and 09/07/2023 at 115 pounds (per hospital noted on weight record), 10/06/2023 at 112 pounds, 11/03/2023 at 114 pounds, 12/08/2023 and 01/03/2024 at 111 pounds (digital scale noted on weight record) and on 02/01/2024 at 110 (per doctor's office noted on weight record).

I reviewed Resident A's provider contact sheets and noted the following:

- 01/10/2023, nurse practitioner (NP) wrote one-to-one supervision with standby assist due to unsteady gait, gait belt required for transferring and ambulating. Ensure meal replacement one can three times per day, full assist and monitoring to reduce risk for aspiration: mechanical soft diet.
- 01/24/2023, NP wrote maintain 24-hour supervision and safety with full transfer assist.
- 03/09/2023, NP referred to physical therapy (PT) and occupational therapy (OT) for unsteady gait: continue safety management; one-to-one supervision 24-hours per day.
- 04/13/2023, NP wrote, full assist one-to-one supervision with toileting, showering, bathing, eating, transferring, and ambulating. Continue working with Dr. Markle (gastrointestinal) and discuss with mother regarding nutrition management.

HM stated it was recommended on 05/25/2023 after the peg tube was put in that Resident A is fed five times per day via peg tube along with 180ML of water each time. Resident A was being fed at 8AM, 12:30PM, 3PM, 6PM, and at 8PM. HM stated that staff were required to document Resident A's feedings completed after each time. I reviewed Resident A's food/waterlog from 11/2023-03/2024 and found that there are missing dates/times of when Resident A was fed. For example, on 01/04/2024 and 03/06/2024 at 3PM staff did not document Resident A's feeding. On 01/07/2024, 01/11/2024, and 01/14/2024, staff did not document Resident A's feedings for 6PM and 8PM, on 02/29/2024, 03/02/2024, 03/05/2024, 11/03/2023, and 10/16/2023 staff did not record Resident A's feedings at 6PM and at 8:30PM, on 08/26/2023 staff did not record any feedings as there is a question mark underneath the date. HM stated although the information was missing from the food log, staff did feed Resident A during the times he was supposed to have been fed. HM also reported that Resident A was getting ample amount of water during each feeding even though he was hospitalized several times for dehydration.

HM was interviewed regarding Resident A's wounds. She was surprised to hear the number of wounds found on Resident A at time of admission on 03/08/2024 because Elara's RN, Collette was present and noted only one wound on his coccyx, but the wound was not open according to the HM. RN Malia showed first shift staff how to clean and care for Resident A's wound. Then first shift staff trained all other staff on how to clean and care for Resident A's wound. There were no pictures taken by Hidden Acres Manor of the wounds. The only open bedsore was the one on the coccyx. According to the HM, Resident A did not have a wound until he returned from Trinity Health Hospital on 02/21/2024. Staff were advised to reposition Resident A every one-to-two hour and change every couple of hours. The wound needed to be changed twice daily. Staff were

supposed to clean the wound with foam, apply ointment provided by Elara HHC, pack inside of the wound and bandage it. Staff would do this twice daily or more if needed. The RN never informed them on 03/08/2024 that the wound was at stage 4. The staff did what they were supposed to do by following Elara HHC recommendations.

On 03/20/2024, I interviewed direct care staff (DCS) Abby Weidel regarding the allegations. Ms. Weidel has been working for this corporation since 06/2023. She works second and third shift. She sometimes works four-five days a week and other times two double shifts. Resident A was being fed through a feeding tube five times a day with a full bottle of water during each feeding and extra water between feedings. Ms. Weidel stated, “While I worked, he got three full 16 ounces of water.” She does not know why he was dehydrated several times he was hospitalized. Ms. Weidel had no concerns about Resident A’s weight loss. She stated, “there’s no concerns about his weight,” since she has been with this corporation. He receives feedings through the peg tube and there are no concerns.

Ms. Weidel was interviewed regarding the wound on Resident A’s coccyx. Ms. Weidel stated the coccyx wound was open, but she is unsure what stage it was. She believes she discovered the wound after Resident A returned from the hospital in 01/20/2024, but the wound had not opened until Resident A returned from the hospital on 02/06/2024. During her shift, she would reposition Resident A every one-half hour to two hours and made sure he was not on a specific side or spot for too long. She would check Resident A every hour and change him every two hours or as needed. She would document this in the community living services (CLS) log. Elara RN trained staff how to care for the open wound. Ms. Weidel would spray the wound with wound spray provided by the RN, then she would use gauze to clean around the wound, put wound cream also provided by the RN and then she would put pressure pads on the sore. She would change Resident A’s wound about four-to-six times during her eight-hour shift. Ms. Weidel stated there were no other open wounds on Resident A; however, there was a pressure sore on the thigh (she cannot recall which thigh) that was starting to open and get black tissue forming around the sore about two weeks before he was hospitalized on 03/08/2024. She only changed and cared for the coccyx wound. Ms. Weidel stated she never began her shift and found the wound soiled and not changed by other staff.

On 03/20/2024, I interviewed DCS Steven Redmond regarding the allegations. Mr. Redmond works first shift from 8AM-4PM. He has worked for this corporation since 02/2023. There are always two DCS per the first shift along with the HM. He usually works upstairs. Resident A was not eating so a peg tube was put in. His feeding schedule was three times per day; 8AM, 12PM, and 3PM. Resident A would also get a bottle of water during each feeding and during medications. The process was to flush the tube with a bottle of water, then the formula for his feeding and then flush again with a bottle of water. This is what they were trained by Elara’s RN. Mr. Redmond stated that Resident A “used to get weighed, but then he became non-ambulatory, so I don’t know how he was weighed.” He stated that the weights on Resident A’s weight records were “guesstimates,” because Resident A was not weighed on the scale. Resident A has always been small, so Mr. Redmond does not believe he was malnourished because

Mr. Redmond followed the feeding schedule provided by Elara RN. Mr. Redmond stated that the Elara RN never informed staff to give Resident A water between feedings; however, during each feeding Resident A was given a bottle of water, so Mr. Redmond does not know why he was dehydrated.

Mr. Redmond was interviewed regarding Resident A's wounds. Mr. Redmond recalls noticing the coccyx wound sometime in 02/2024 but is unsure if he noticed it before or after Resident A returned from the hospital. Mr. Redmond would reposition Resident A every two hours and would check on him every hour and change as needed. Regarding care for the wound, he was trained by Elara RN to take off the gauze, clean it with wound spray, put wound cream on it and then put gauze pads on it after. He stated, "it got worse prior to his hospitalization on 03/08/2024." He stated, "I would reposition him on one side and Resident A keeps moving back on the spot, which made it worse." He also put pillows around Resident A to keep him comfortable, but Resident A would still move on the spot. Mr. Redmond stated he was not aware of any other pressure sores or wounds on Resident A, just the open wound on his coccyx.

On 03/25/2024, I received a call from Dr. Carl Byerly and his wife, Jeanine Byerly regarding the allegations. Mr. Byerly does not know how McLaren Oakland Hospital noted that many wounds on Resident A when Elara's RN was at the home on 03/08/2024 and only noted the wound on the coccyx. He has a signed statement from Elara's RN stating that there was only one bedsore on 03/08/2024. Resident A required a higher level of care, so a 30-day discharge notice was given to Resident A's mother/guardian and to Resident A's case manager at Northpoint BHS, Breanna Allen in July 2023. Dr. Byerly stated that Ms. Allen was actively trying to locate an alternative placement for Resident A but was unsuccessful as the hospital would continue to say that Resident A did not qualify for nursing care and discharge him back to Hidden Acres Manor. Dr. Byerly stated that staff were providing the care for Resident A even though Resident A required a higher level of care. Mrs. Byerly stated one time Trinity Health Hospital wanted to discharge Resident A with a catheter and the group home stated they cannot accept Resident A back with a catheter. The hospital told them that the catheter was out, but when he was discharged home, he had the catheter. Resident A continued to have the catheter and due to the catheter, he was in and out of the hospital with UTI's. The catheter was only cared for by Elara's RN and if staff could not get a hold of the RN, then Resident A would get sent to the hospital. Dr. Byerly believes the staff provided the care to Resident A per Elara's RN's training and recommendation. He did not know that he could have issued an emergency discharge based on Resident A requiring a higher level of care.

On 03/28/2024, I contacted via telephone Elara's Clinical Coordinator Heather. Heather stated that the RN, Malia is no longer employed with Elara. Heather reviewed the notes and provided the following: Wound was discovered on 02/28/2024, it was unstageable which means that something was in the wound bed such as necrotic tissue to determine what stage it was. Prior to 02/21/2024, the RN did not note any wounds on Resident A and the RN is required to complete a full body assessment at each visit, which the RN did. On 02/28/2023, it was noted malnutrition, peg tube and requires full care. The

group home denies any concerns with peg tube feedings. The RN would go into the home and educate staff. On 03/12/2023, Resident A was declining, bedridden so the facility was instructed to reposition every two hours. The RN that was out on 03/08/2024 was Collette. She will have Collette contact me.

On 03/28/2024, I contacted Katie Smith with Northpointe BHS Office of Recipient Rights (ORR) regarding Resident A. On 02/20/2024, she conducted an on-site visit at Hidden Acres Manor to complete a site review and to meet Resident A. She reviewed fire drills, e-scores and met with Resident A. She stated, “he did not seem to be in the right placement.” Resident A was laying on a lazy boy, in and out of sleep. He was very thin. He is non-verbal and did not engage. Ms. Smith immediately got on the phone with their placement coordinator Breanna Allen who is also Resident A’s case manager and advised her that Hidden Acres Manor was no longer an appropriate placement for Resident A due to her observations. Hidden Acres Manor was not receiving payments for Resident A’s cost of care from Resident A’s mother/guardian; therefore, she was taken to Probate Court. It’s unclear what the status of that case was. Ms. Smith is supposed to receive incident reports (IR) regarding Resident A whenever he is hospitalized and any changes in his care, such as wounds. Ms. Smith has only received a total of three incident reports, 04/02/2023, 02/21/2024, and 03/08/2024. She was never informed of an open wound on his coccyx or about dehydration. Ms. Smith was told by Ms. Allen that the hospital did not qualify Resident A for a nursing home; therefore, the hospital continued to discharge Resident A back to Hidden Acres Manor. Ms. Smith stated that the home is required to provide monthly updates to Ms. Allen regarding Resident A and that Ms. Allen’s job is to ensure that the home is completing assessment plans annually.

On 03/28/2024, I interviewed DCS Sherry McLean via telephone regarding the allegations. Ms. McLean works first shift and has been with this corporation since 04/01/2023. During her shift, Resident A is supposed to be fed three times via peg tube, 8AM, 12PM and at 3PM as instructed by Elara’s RN. Whenever Ms. McLean does the feedings, she gives Resident A a full bottle of water, so she is unsure why he is dehydrated. She does not know why he was malnourished or about his weight loss. Resident A was non-ambulatory, and she is unsure how he was weighed because she did not weigh him. She had no other information to provide.

Ms. McLean was interviewed regarding Resident A’s wounds. Resident A had a wound on his tailbone that was partially healing but open. She noticed the wound prior to Resident A’s hospitalization at Trinity Hospital on 02/21/2024, but that the wound “looked worse,” after he returned from that hospitalization. Elara RN educated first shift staff on how to care for the wound. Ms. McLean treated it by first cleaning the wound with wound spray, then apply wound honey cream provided by the RN, then sealing it up with pressure pads. During her shift, she changed the wound about two-three times. Resident A’s doctor was ordering liquid to soak the gauze to pack the wound but by the time Hidden Acres Manor received the liquid, Resident A was hospitalized on 03/08/2024 and did not return. Ms. McLean stated that “Resident A had skin breakdowns all over his body. Pillows were put between his legs, but that was not

working too. Resident A wasn't in a proper placement as he needed to be in a skilled nursing place." Resident A was moving a lot, so whenever she repositioned him every two hours, he would be back in the same spot. She observed skin breakdowns on his shoulders, knees, thighs, and his hips. She stated, "I'm unsure why the group home continued to accept him back after he was in the hospital. In February 2024, we were not supposed to receive him back was my understanding but then he returned."

On 03/28/2024, I interviewed via telephone assistant HM Savonne Keys. Mr. Keys works third shift. During third shift, Resident A was not required to get any feedings nor was he receiving any medications during third shift either for him to receive any water. Therefore, he is unsure about Resident A being malnourished or dehydrated.
Mr. Keys was interviewed regarding the wound allegations. He stated that he had hurt his foot and had not been working downstairs since 03/04/2024; therefore, from what he recalls, he was not aware of an open wound but was aware of a bedsore on the lower end of Resident A's back. An ointment cream was applied every two-three hour and Resident A had to be repositioned every 30 minutes to an hour; however, Mr. Keys did it more often because, "Resident A was making sounds of being in discomfort." Regarding the wound care, Elara's RN trained first shift staff and then the HM put in the "group text chat," how to care for the wound. He was not trained by other staff nor the RN nor the HM, just information was passed along via group chat. He believes he saw the bedsore after his 02/2024 hospitalization. Mr. Keys stated, "Resident A was taken care of to the best of our ability. He required a one-to-one because of his higher level of care and decline in health. I told management that Resident A needed a one-to-one and that some staff are not qualified to care for Resident A because Resident A needed a skilled nurse due to his medical needs."

On 03/28/2024, I interviewed via telephone DCS Kiyana Harrison regarding the allegations. Ms. Harrison works third shift but sometimes also second shift. She has been working for this corporation since 07/2023. During third shift, Resident A does not get any feedings or medications. The only time a medication may be given if the doctor prescribes oral antibiotics. She stated he is usually sleeping during her shift. However, when she worked second shift, she was responsible for feedings that he was required to receive five times per day. She would do the feedings followed by a bottle of water during each feeding period and during his medications.

Ms. Harrison was interviewed regarding Resident A's wounds. She was aware of the wound on Resident A's coccyx. She looked at the wound and it appeared "a bit open," to her. Ms. Harrison noticed the wound after he returned from the hospital in 02/2024. Elara's RN was treating the wound. Her job was to keep it dry and to reposition Resident A every two hours but then that changed to every hour before his hospitalization on 03/08/2024. She would check him to ensure he was not soiled and if he was, she would change him. She would check the wound and if it was oozing, then she would change the bandage, put cream given by the RN and then reposition him. She was unaware of any other bedsores or pressure wounds.

On 03/28/2024, I interviewed DCS Tya Vanderson via telephone regarding the allegations. Ms. Vanderson works both second and third shift. She has been with the corporation since 04/2023. She only worked upstairs, so she did not have much contact with Resident A. However, she did assist other DCS in changing Resident A, but she does not know if there were any concerns regarding Resident A being malnourished or dehydrated. She stated, “I always saw staff pushing fluids via his peg tube.” She had no other information.

Ms. Vanderson was interviewed regarding Resident A’s wounds. She stated, “I didn’t know he had a wound.” I helped in changing only sometimes but nothing else. She had no other information.

On 04/04/2024, I received a return call from Northpointe BHS case manager Breanna Allen regarding Resident A. Ms. Allen is both Resident A’s case manager and the placement coordinator. Resident A was placed at Hidden Acres Manor in December 2022. He did not have medical needs at that time. He was physically healthy. Around 01/16/2023, the home began reporting concerns. The first concern was Resident A “not eating,” and “pocketing food.” He was hospitalized for dehydration and put on a pureed diet with clear liquids. Resident A went back into the hospital in 03/2023 and had OT/PT/Neuro/Gastro following him. The home reported “doing well.” In 04/2023, he was refusing food and losing weight; supplement drink, Ensure was prescribed as part of his diet. In 06/2023, she received information that he was hospitalized again, infection due to catheter. It was discussed that he needed to be on a “straight catheter,” to have him return to the home. Also, discussion at this time regarding discharge to nursing home, but then hospital discharged him back to Hidden Acres Manor without the catheter. Ms. Allen contacted Dr. Carl Byerly on 06/26/2023 to discuss long term care due to Resident A’s health concerns; losing weight and if Resident A continues to lose weight, then he needed to be discharged to a nursing facility. Resident A’s mother/guardian was given a 30-discharge notice; however, Resident A continued to go into the hospital. Ms. Allen stated, “I told Dr. Byerly refuse to take him back because he required a higher level of care, but the home continued to take him back until his most recent hospitalization on 03/08/2024.” Ms. Allen was made aware of Resident A’s bedsore after he was hospitalized on 03/08/2024. She was not aware of the wound prior to 03/08/2024. She was also informed of a pressure sore on Resident A’s left and right shoulder. Ms. Allen believes that the home did not lack in providing care for Resident A. However, Resident A did require a higher level of care that Hidden Acres Manor did not have, such as skilled nursing.

On 04/09/2024, I received a telephone call from Dr. Carl Byerly. He will provide the weekly weight records for Resident A as the home was following instructions per the hospital’s discharge papers on 01/17/2023 and weighed Resident A weekly. Dr. Byerly stated that Resident A’s assessment plan was completed annually 12/21/2022 and 01/01/2024, per the licensing rules even though Resident A’s medical needs changed, and Resident A declined sometime between 01/2023-04/2023. Dr. Byerly did not issue the emergency discharge because lack of cooperation from Resident A’s mother/ guardian and Trinity Health “refused to keep him and qualify him for a nursing home.”

On 04/15/2024, I emailed Dr. Carl Byerly advising him that I do not have an updated assessment plan completed between 12/21/2022 (admission) and 12/20/2023 (vegetative state). Dr. Byerly emailed back the following: “Documents show that resident WAS NOT in a vegetative state 13 days BEFORE the Assessment Plan was written – he started to SLOWLY decline within that time frame AFTER his discharge on 12/7/23. ASSESSMENT PLAN completed on 12/23 was within 7 days of his follow-up at PCP and 13 days from the hospital discharge, at which the hospital had EM at BASELINE. While the decline was a gradual decline and not due to a specific medical event but increasing weakness due to UTI’s, pinpointing the exact timing that “vegetative state” would be completely impossible. HOWEVER, the assessment was scheduled and completed in a timely fashion reflecting his declining state to “vegetative”. The assessment addresses all necessary information pertinent to his needs after this decline, making the 12/23 Assessment VALID and coincided with the new Healthcare appraisal that was completed.”

I received Resident A’s weekly weight records, and they were completed weekly.

NOTE: According to the provider contacts, Resident A’s decline began on 01/10/2023 when the NP noted one-to-one supervision due to unsteady gain, 01/24/2023 full transfer assist, 03/09/2023 one-to-one supervision and again on 04/13/2023, one-to-one supervision with toileting, showering, bathing, eating, transferring, and ambulating. The assessment plan was never updated to reflect these needs and how staff were to meet these needs.

On 05/02/2024, I left a message for OT Joan Adams with Elara HHC. Ms. Adams never returned my call.

On 05/13/2024, I contacted via telephone Regency of Waterford social worker, Mayse regarding Resident A’s status. Mayse stated that Resident A’s wounds are not getting better since admission as Resident A has been in and out of the hospital; however, as of 05/02/2024, Resident A gained weight since admission. Resident A weighed 102.8 pounds at admission on 03/16/2024 and then weighed 108.6 pounds as of 05/02/2024. The nurse will be recommending hospice due to Resident A’s medical decline.

On 05/20/2024, I attempted to reach licensee designee Neiman Byerly via telephone for the exit conference but was unsuccessful as his voice mail box is full. I contacted Dr. Carl Byerly who stated he will have Neiman call me.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written

	assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home.**
ANALYSIS:	Based on my investigation and information gathered, Resident A required a higher level of care than the staff at Hidden Acres Manor could provide. Resident A was admitted on 12/21/2022 to Hidden Acres Manor. He was ambulatory and could feed himself. Shortly after, around 01/2023, Resident A began declining. He was not eating, required one-to-one supervision and a full assist with all his care. Due to Resident A requiring a higher level of care, Hidden Acres Manor issued Resident A's mother/guardian a 30-day discharge notice on 06/28/2023. Resident A continued to decline requiring a peg feed tube and a catheter. He was in and out of hospitals for a total of 12 times after being admitted into Hidden Acres Manor. Several of these hospitalizations were due to malnourishment, dehydration, and UTI's. Hidden Acres Manor continued to accept Resident A back from the hospital knowing he required a higher level of care that Hidden Acres Manor could not provide. Resident A lost a tremendous amount of weight, 25 pounds between 03/01/2023 and 04/18/2023 and continued to lose weight because he was not eating and in and out of the hospitals. In addition, he had an unstageable wound on his coccyx that was not healing. DCS Sherry McLean stated that Resident A required a higher level of care, and it was her understanding that Resident A would not return to Hidden Acres Manor after his hospitalization in 02/2024, but the home accepted him again. Ms. McLean stated, "I'm unsure why the group home keeps returning him back here." According to the assistant HM Savonne Keys, staff were providing the best care they could to Resident A, but he told management that Resident A needs one-to-one staffing who are qualified to care for him such as a nurse and some staff at Hidden Acres Manor are not qualified." Resident A's case manager Breanna Allen informed Dr. Carl Byerly after providing the 30-day discharge to Resident A's guardian to "refuse," and not to "take him back," but Dr. Byerly continued to take Resident A back until his most recent hospitalization on 03/08/2024.
CONCLUSION:	**VIOLATION ESTABLISHED**

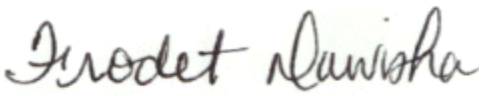
APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Based on my investigation and information gathered, Resident A's assessment plan was not updated between 1/10/2023-01/01/2024 to reflect his decline and his needs and how staff were to meet those needs. An assessment plan was completed at the time of Resident A's admission on 12/21/2022 that stated Resident A was fully ambulatory, can feed self, needs food cut up. However, according to the health care appraisal completed on 12/20/2022 by a medical professional, Resident A required one-to-one feeding supervision - dysphagia/mechanical soft, Ensure Plus HP twice daily with breakfast and lunch, which was not reflected on the assessment plan. In addition, Resident A's medical needs declined on 01/10/2023 when Resident A required one-to-one supervision due to unsteady gait and continued to decline per his provider contact notes when he was a full assist with all his care as of 04/13/2023. Hidden Acres Manor did not update the assessment plan to reflect these needs and how staff were meeting these needs. However, an annual assessment plan completed on 12/20/2023 indicated "vegetive state" throughout the assessment plan even though Resident A was not in a vegetative state.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2023A0605006, dated 11/18/2022, CAP dated 01/24/2023**

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: **(b) special diets**
ANALYSIS:	Based on my investigation and review of Resident A's food logs, staff were not following instructions of Resident A's physician with regard to Resident A's special diet - feeding schedule. I reviewed Resident A's food/waterlog from 11/2023-03/2024 and found that there are missing dates/times of when Resident A was fed. For example, on 01/04/2024 and 03/06/2024 at 3PM staff did not document Resident A's feeding. On 01/07/2024, 01/11/2024, and 01/14/2024, staff did not document Resident A's feedings for 6PM and 8PM, on 02/29/2024, 03/02/2024, 03/05/2024, 11/03/2023, and 10/16/2023 staff did not record Resident A's feedings at 6PM and at 8:30PM, and on 08/26/2023 staff did not record any feedings as there is a question mark underneath the date. It is unclear if staff forgot to document Resident A's feedings or if Resident A was not fed during those times not documented by staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

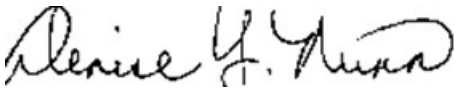
I recommend revocation of the license.



05/20/2024

Frodet Dawisha Date
Licensing Consultant

Approved By:



05/20/2024

Denise Y. Nunn Date
Area Manager