GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 3, 2024

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

RE: License #: AL340338193
Investigation #: 2024A0622025
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 #:	2024A0622025
Complaint Receipt Date:	05/02/2024
Investigation Initiation Date:	05/02/2024
Report Due Date:	07/01/2024
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?
On 4/29/24 an incident report was sent to office of recipient rights that staff found multiple medication bottles with medications in them and inhalers in a residents drawers in their bedroom.	No
Additional Findings	Yes

III. METHODOLOGY

05/02/2024	Special Investigation Intake 2024A0622025
05/02/2024	Special Investigation Initiated Phone call with Jenny Morgan, ORR
05/10/2024	Inspection Completed-BCAL Sub. Compliance. Interviewed DCW Desire Wyatt.
05/13/2024	Inspection completed on-site. Interviewed Resident A.
05/31/2024	Exit Conference with Jessica Adams, administrator.

ALLEGATION: On 4/29/24 an incident report was sent to office of recipient rights that staff found multiple medication bottles with medications in them and inhalers in a resident's drawers in their bedroom.

INVESTIGATION:
On 05/02/2024, I received this complaint through the Bureau of Community and Health Systems online complaint system. According to the complaint, the office of recipient rights received an incident report documenting direct care staff found multiple medication bottles and inhalers in Resident A's bedroom. The medication was in her dresser drawer. The complaint stated that Resident A is on a specialized residential contract and requires assistance with medication administration.

On 05/02/2024, I interviewed Jenny Morgan, recipient right officer for Ionia County. Ms. Morgan confirmed the incident report that she received and reported that picture documentation was also received with all the medications that were found. Ms. Morgan stated that the medications were all from before she moved into the facility and she was concerned direct care staff did not go through her belongings at admission, nor are doing regular bedroom checks. Ms. Morgan also reported that Resident A shares a bedroom with other residents.

On 05/10/2024, I completed an unannounced onsite investigation to Harrison House AFC. During the onsite investigation, I interviewed direct care worker, Desire Wyatt

in person. DCW Wyatt confirmed she was the staff member that found Resident A's medications. She reported that she was in the bedroom and Resident A's drawer was open and she observed a medication bottle. DCW Wyatt reported that Resident A was at Mission Point in Belding due to COPD at the time of finding the medication. Therefore, she called Resident A's guardian to receive permission to go through her belongings. Based on the picture provided, 22 medications that should have been properly locked were found in Resident A's bedroom. DCW Wyatt reported that Resident A is allowed to have an emergency inhaler, per her doctor. It was reported that Resident A used to keep her inhaler on top of her dresser in her bedroom. DCW Wyatt reported that she was concerned that Resident A was using her inhaler more than required.

On 5/10/2024, I attempted to interview Resident A in person, but she was admitted to Mission Point Hospital in Belding due to her COPD. It was reported that she should be returning to the facility on 05/12/2024. Documentation was reviewed during the onsite.

On 5/13/2024, I completed an unannounced onsite investigation to Harrison House AFC. During the onsite investigation, I reviewed documentation, viewed Resident A's bedroom, and interviewed Resident A. Resident A shares a bedroom on the second floor with three other residents.

On 05/13/2024, I interviewed Resident A in person. Resident A reported that she has always had an emergency inhaler and now uses a round inhaler. She reported that just recently staff took all her medications and inhaler, and they are locked up in the medication cart. She stated that she was not comfortable with staff having her inhaler, as she does not want to find staff if she has an emergency. Resident A reported that the medication found, was old and from before she moved into the AFC facility. Resident A reported that she was unaware that medication was required to be locked up.

Based on the picture provided, 11 inhalers were found in Resident A's bedroom, 8 prescribed medication bottles and 3 over the counter medication bottles.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan

	Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	According to DCW Wyatt, Resident A was allowed to have an inhaler for emergencies, but Harrison House AFC was not requiring Resident A to keep her inhaler locked in her bedroom. It was reported by staff and Resident A that she was not locking up her inhaler. Resident A was admitted to Harrison House on 11/16/2023 and staff reported they were not aware of the medications as they were not required to search all Resident A's belongings. At the time of inspection, no unlocked mediations were found in Resident A's bedroom, as staff had locked up all medications found and took care of this prior to the onsite investigation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 05/10/2024, I completed an unannounced onsite investigation to Harrison House AFC. During the investigation, I attempted to review Resident A's most recent *Health Care Appraisal* to verify currently prescribed medications; however, at the time of investigation, a health care appraisal was not available to be reviewed. Resident A was admitted to Harrison House AFC on 11/16/2023. According to DCW Wyatt, all Resident A's paperwork that was available was in her resident record.

On 05/02/2024, I reviewed previous renewal inspections, dated 9/17/2021 and 09/15/2023. Renewal Licensing Study Reports dated 09/17/2021 and 09/15/2023 cited violation for the licensee not having updated health care appraisals for residents. The corrective action plan for 09/17/2021 stated the following:

"[Resident A] was accepted with a healthcare appraisal that was current but had another AFC name on it. Staff kept it in the file until a new one could be completed with our home's name on it. Staff has taken note that this appraisal should have stayed in the file along with the original admission clearance. This information was communicated immediately, and the home manager will assure compliance in the future."

The corrective action plan from 09/15/2023 stated the following:
"The doctor will complete on next visit."

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	At the time of inspection, a health care appraisal was not available within Resident A's file despite Resident A living in the facility for over two months. This rule has been cited during the past two renewal inspections.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED. [SEE RENEWAL LICENSING STUDY REPORTS DATED 09/17/2021 and 09/15/2023 AND CAPS DATED 09/18/2021 and 09/13/2023.]**

INVESTIGATION:
During an onsite unannounced investigation on 05/10/2024, DCW Desire Wyatt reported that Resident A had physician permission to keep her inhaler with her and in her room. Resident A also confirmed that she was allowed to keep her inhaler on her person until recently when staff found her other medication.

On 05/10/2024 and 05/13/2024, I reviewed Resident A's resident record and did not locate any documentation, such as physician's order, from a physician stating that Resident A can keep her inhaler on her person.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(3) Unless a resident's physician specifically states otherwise in writing, the giving, taking, or applying of prescription medications shall be supervised by the licensee, administrator, or direct care staff.

ANALYSIS:	Harrison House AFC Staff and Resident A reported Resident A's doctor had given approval for Resident A to keep her inhaler on her person. At the time of inspection there was no physician statement or prescription in writing confirming that Resident A can keep her inhaler unlocked within the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

05/24/2024

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Amanda Blasius Date
Licensing Consultant

Approved By:

06/03/2024

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Dawn N. Timm Date
Area Manager