GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 24, 2024

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

RE: License #: AL340338193
Investigation #: 2024A0622035
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 #:	2024A0622035
Complaint Receipt Date:	06/04/2024
Investigation Initiation Date:	06/04/2024
Report Due Date:	07/04/2024
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?
Only one staff available during the overnight shift.	Yes
Resident A received the wrong medication on 6.2.24 and went to the hospital.	Yes
No mattress covers are being used on resident beds.	No
Concerns regarding how Resident A is receiving his is prescribed Metformin.	No

III. METHODOLOGY

06/04/2024	Special Investigation Intake 2024A0622035
06/04/2024	Special Investigation Initiated – Telephone call to Resident A's guardian.
06/05/2024	APS Referral- APS is investigating allegations.
06/06/2024	Paperwork received from guardian.
06/07/2024	Inspection Completed-BCAL Sub. Compliance
06/18/2024	Onsite completed, collected paperwork and interviewed direct care workers Desire Wyatt and Hailey Clark.
06/21/2024	Phone call with APS investigator, Vicki Pohl
06/25/2024	Exit Conference with Jessica Adams.

ALLEGATION: **Only one staff available during the overnight shift.**

INVESTIGATION:
On 06/04/2024, I received an anonymous complaint regarding several allegations for Harrison House. One of the allegations reported that Harrison House has a live in staff that is present for the 3rd shift. Complainant stated that the live in staff is asleep during the shift and only gets up occasionally to check on the residents. Complainant stated that she is concerned because she is aware that at least two residents require two direct care staff members to assist with transfers and/or mobility and if the facility had a fire, one staff member could not get all the residents out of the home.

On 06/07/2024, I completed an unannounced onsite investigation to Harrison House AFC. During the onsite I interviewed direct care worker (DCW), Desire Wyatt in

person. I requested the staff schedule to view the third shift and she reported that there is no schedule for the third shift as the facility has a live in staff at the facility. I had asked if the live in staff is awake during the 3rd shift and she reported no, but she occasionally gets up to check on the residents. It was reported that she has a call bell system in case a resident needs assistance. DCW Wyatt reported that the facility has four residents that require two direct care staff members to assist with transfers and/or mobility.

On 06/07/2024 and 06/18/2024, I viewed documentation for the four residents that require two direct care staff members assistance with transfers and/or mobility and Evacuation Scores (E-Scores) for May and June 2024. A doctors note for Resident A, dated 5/2/24 stated the following:

"[Resident A] is not to have unattended transfers. He is always to be a two person assist."

Assessment Plan for AFC Residents toileting needs: staff will assist [Resident A] will all incontinence needs.

Documentation for Resident B's *Assessment plan for AFC residents* stated the following:

"[Resident B] requires a two staff assist with transferring."

Toileting: Staff will provide total care for [Resident B's] incontinence supplies

According to DCW Wyatt, Resident C uses a Hoyer lift, due to her breaking both of her legs. Two staff are needed to operate a Hoyer lift. Documentation for Resident C's *Assessment plan for AFC residents* states the following:

"Physical limitations: No walking or Standing.

Walking/Mobility: Staff will provide full assistance and encourage her to self-propel.

Toileting: Incontinence of bowel and bladder

Doctors note: [Resident C] is a two person assist with any/all transfers."

Documentation from Resident D's doctor stated the following:

"[Resident D] is a two person assist with any/all transfers."

Evacuation Score documentation was reviewed from April 2024 and June 2024. The first shift score for April 2024 was 1.5 which was a prompt level of evacuation difficulty. This shift had three staff available. The second shift from April 2024 was 2.25 which was a slow level of evacuation difficulty. The second shift had two staff working. The third shift from April 2024 was 5.63 which was an impractical level of evacuation difficulty. The third shift had one staff working. The E-Scores for June 2024 were 1.13 for first shift which was a prompt level of evacuation difficulty. This shift had three staff available. The second shift from June, 2024 was 1.7 which was a slow level of evacuation difficulty. The second shift had two staff working. The third shift from June 2024 was 4.25 which was a slow level of evacuation difficulty. The third shift had one staff working.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on the documentation reviewed for all four residents, it was determined that four residents require two direct care staff members to assist with transfers and/or mobility. Evacuation Scores documented that unless the facility has three direct care staff available, the scores were slow or impractical for their level of evacuation difficulty. Based on interviews and documentation from the Evacuation Scores, my review of the staff schedule and interviews, only one direct care staff is available for third shift, which is from 10pm-7am. All four residents are also incontinent and it is unclear how their toileting and transfer needs are completed with only one sleeping direct care staff member during third shift. Harrison House AFC is not a sprinkled facility, therefore if a fire occurred, Residents A, B, C and D may not be able to evacuate the facility safely or at all during the hours of 10pm-7am (9 hour shift) due to only one staff being available.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A received the wrong medication on 6/2/24 and went to the hospital.

INVESTIGATION:
On 06/04/2024, I received an anonymous complaint regarding Resident A receiving a medication prescribed for another resident resulting in Resident A being sent to the hospital for observation. Complainant stated DCW Hailey Clark had given DCW Chloe Petersen, who is not trained to administer resident medication, medication to pass to a resident. DCW Chloe Petersen gave that medication to the wrong resident.

On 06/07/2024, I completed an unannounced onsite investigation to Harrison House AFC. I interviewed DCW Desire Wyatt in person. She stated that the medication error did occur on 6/2/24, but she only arrived at the home after the incident. She explained that DCW Hailey Clark and Chloe Petersen were working the first shift. DCW Wyatt stated DCW Hailey Clark was passing medication and she had handed medication to DCW Chloe Petersen and told her to give the medication to Resident A. DCW Wyatt reported that the medication was supposed to be for another resident, not Resident A. DCW Wyatt reported that Chloe Petersen is also not fully medication trained yet. DCW Wyatt explained that she instructed staff to call 911

and they sent Resident A to the hospital via ambulance to be checked and monitored. DCW Wyatt stated that Hailey Clark has been on leave and will re-do medication administration training.

On 06/07/2024, I reviewed documentation regarding the medication error. An incident report was reviewed, along with discharge paperwork from the hospital. The discharge paperwork confirmed that he was discharged on 6/2/24 after tests were completed and Resident A was instructed to follow up with his primary physician. Workforce background checks were reviewed for Hailey Clark and Chloe Petersen. Hailey Clark's training was reviewed, and she has completed medication administration training. Chloe Petersen has not completed medication administration training.

On 06/18/24, I interviewed DCW Hailey Clark in person at Harrison House AFC. She reported that only two staff were working on 6/2/24 during the first shift and she was trying to complete medications, assist residents and also help with breakfast. DCW Clark stated that she had asked Chloe Petersen to give a resident their medication and DCW Petersen ended up giving it to the wrong resident. DCW Clark stated that she does not recall saying the wrong person's name but may have made the mistake. DCW Clark stated that the incident is her fault, and she was unaware that she could not pass the medication to another staff member to administer. DCW Clark also stated that she was not aware that DCW Petersen was not medication trained.

On 06/21/2024, I interviewed DCW Chloe Petersen via phone. DCW Petersen reported that she no longer worked at Harrison House AFC for reasons unrelated to this incident. DCW Petersen stated that DCW Hailey Clark was very stressed out on 06/2/24 and she ended up bringing her children to work with her. DCW Petersen stated that they were in the kitchen and DCW Clark asked her to bring the meds to Resident A. DCW Petersen stated that Resident A had asked for coffee, so she made a pot of coffee and then brought the medication to Resident A. When she returned to the kitchen, she informed DCW Clark that Resident A had the medication, which was when DCW Clark realized the error. DCW Petersen stated that she ran back to Resident A's bedroom to confirm that he had taken the medication, which he had. DCW Petersen stated that DCW Clark borrowed her phone to call the home manager. DCW Clark explained that she observed DCW Clark yelling on the phone and then she stormed out of the facility and left. DCW Petersen stated that 911 was called and DCW Desire Wyatt soon arrived at the facility.

On 06/21/2024, I interviewed adult protective services worker, Vicki Pohl via phone. She confirmed that she is investigating this complaint but has not completed her investigation.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Based on the interviews, it was established that Resident A was given a medication that was prescribed to another resident due to medication errors from DCW Hailey Clark. DCW Clark was unaware that she could not hand medication over to another staff member to administer. In addition, DCW Petersen was not trained to administer medication. Due to miscommunication, a medication error occurred resulting in Resident A going to the hospital for observation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: No mattress covers are being used on resident beds.

INVESTIGATION:
On 06/07/2024, I completed an unannounced onsite investigation to Harrison House AFC. During the unannounced onsite investigation, I viewed the bedroom for Resident A and viewed bed coverings for the two beds in the bedroom. Both beds in the bedroom, had mattress covers present during the investigation.

APPLICABLE RULE	
R 400.15410	**Bedroom furnishings.**
	(5) A licensee shall provide a resident with a bed that is not less than 36 inches wide and not less than 72 inches long. The foundation shall be clean, in good condition, and provide adequate support. The mattress shall be clean, comfortable, in good condition, well protected, and not less than 5 inches thick or 4 inches thick if made of synthetic materials. The use of a water bed is not prohibited by this rule.
ANALYSIS:	During the unannounced onsite investigation, I viewed two beds and both mattresses had mattress covers. It was determined that that the mattresses are well protected.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Concerns regarding how Resident A is receiving his is prescribed Metformin.

INVESTIGATION:
On 06/04/2024, I spoke with Resident A's guardian. She stated that she is concerned about how Resident A was still being prescribed Metformin, as the pharmacy stopped sending the prescribed Metformin in November of 2023. Guardian A1 provided documentation of prescribed medications for Resident A from 10/24/23-02/20/2024. According to her documentation, Metformin was refilled on 10/24/2023 with 60 pills. Guardian A1 stated that the doctor is trying to fill a new medication that has the same function as Metformin, but she was not aware if Resident A was still receiving Metformin.

On 06/07/2024, 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 reported that Resident A is no longer prescribed Metformin. During the onsite investigation, I viewed Resident A's medication administration records. According to the medication administration records, Resident A left the facility on the evening of October 24th and did not return to the facility until November 29th, 2023. According to his medication chart, Resident A's Metformin was discontinued on 12/20/2023. DCW Wyatt reported that Resident A was having significant side effects from the Metformin therefore the medication was discontinued.

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 Page 21 *Courtesy of Michigan Administrative Rules* 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:	Resident A's medication chart was reviewed, and it was confirmed that his Metformin was discontinued on 12/20/2023 due to side effects. Therefore, it was confirmed that Resident A is no longer receiving Metformin.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

06/24/2024

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Amanda Blasius Date
Licensing Consultant

Approved By:

06/25/2024

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Dawn N. Timm Date
Area Manager