GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 29, 2024

Jennifer Bhaskaran
Alternative Services Inc.
Suite 10
32625 W Seven Mile Rd
Livonia, MI 48152

RE: License #: AS190010545
Investigation #: 2024A0466050
Bradford Home

Dear Ms. Bhaskaran:

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,

Julie Elkins

Julie Elkins, 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 #:	AS190010545
Investigation #:	2024A0466050
Complaint Receipt Date:	07/05/2024
Investigation Initiation Date:	07/05/2024
Report Due Date:	09/03/2024
Licensee Name:	Alternative Services Inc.
Licensee Address:	Suite 10 32625 W Seven Mile Rd Livonia, MI 48152
Licensee Telephone #:	(248) 471-4880
Administrator:	Bonnie Snider
Licensee Designee:	Jennifer Bhaskaran
Name of Facility:	Bradford Home
Facility Address:	7757 S Chandler Rd St Johns, MI 48879
Facility Telephone #:	(517) 651-5821
Original Issuance Date:	11/23/1981
License Status:	REGULAR
Effective Date:	06/25/2023
Expiration Date:	06/24/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION:

	Violation Established?
Resident A's foot was injured on 06/25/2024 by DCW Amy Ramirez while she was taking her to her bedroom in a wheelchair.	No
Additional Findings	Yes

III. METHODOLOGY

07/05/2024	Special Investigation Intake 2024A0466050.
07/05/2024	APS Referral Tom Hilla assigned.
07/05/2024	Special Investigation Initiated – Telephone call licensing consultant Jennifer Browning.
07/09/2024	Contact - Telephone call received to Jennifer Browning from APS Hilla.
07/09/2024	Inspection Completed On-site.
08/21/2024	Contact- Document sent to licensee designee Jennifer Bhaskaran.
08/26/2024	Contact- Telephone call recevied from APS Tom Hilla.
08/26/2024	Exit Conference with licensee designee Jennifer Bhaskaran.

ALLEGATION: Resident A's foot was injured on 06/25/2024 by DCW Amy Ramirez while she was taking her to her bedroom in a wheelchair.

INVESTIGATION:
On 07/05/2024, Complainant reported that Resident A is 43 years old, non-verbal and she resides at Bradford home which is an adult foster care (AFC) facility. Complainant reported that on 6/25/2024 night shift direct care worker (DCW) Amy Ramirez was taking Resident A to her room in her wheelchair. Complainant reported that when DCW Ramirez was turning Resident A into her room DCW Ramirez "rammed" Resident A's foot into the door jamb which caused bruising. Complainant reported that because of having her foot "jammed" into the door, Resident A cannot bear any weight on it. Complainant reported Resident A was taken to the hospital the next day. Complainant reported Resident A's foot is not broken but is badly bruised and the bruising continues to get worse. Complainant expressed concern with the amount of force it must have taken to cause the injury. Complainant reported that there are no cameras and DCW Ramirez is still working at the facility.

On 07/05/2024, licensing consultant Jennifer Browning reported that she interviewed Complainant who reported that she is also a direct care staff member at Bradford Home. Complainant reported that the staff member who injured Resident A is Amy Ramirez and she has worked at the facility for a couple years. Complainant reported that DCW Autumn McGovern took Resident A to the hospital on 06/26/2024 and she was released the same day. Complainant reported that the radiologist report said that the foot was badly bruised, to keep it elevated, iced, and administer Tylenol as needed.

On 07/09/2024, licensing consultant Jennifer Browning interviewed APS Hilla who reported that on 06/25/2024, DCW Ramirez was taking Resident A back to her room to change her after she had an incontinence accident and DCW Ramirez hit Resident A's foot on the metal door jamb. APS Hilla reported that Resident A is supposed to be wearing physician prescribed AFO braces to help her ankles steady when she walks. APS Hilla reported that Resident A wasn't wearing the braces which he assumed could have protected her ankles when her foot hit the door jamb. APS Hilla reported that on 06/26/2024, DCW Ramirez called DCW Leonard and DCW Tonya (last name unknown) who was working 2nd shift and notified them both of the injury, but no one took Resident A to the hospital until the evening of 06/26/2024 despite Resident A's foot being swollen and bruised. APS Hilla reported that Resident A was released from the ER the same day and was not hospitalized. APS Hilla reported that DCW Leonard reported notifying Guardian A1 of the situation; however, DCW Leonard didn't mention that medical intervention was not sought until a day and half after the injury occurred. APS Hilla doesn't understand why there was a delay in medical care and why DCW Leonard is not following the established safety plan.

On 07/09/2024, I conducted an unannounced investigation and I reviewed Resident A's record which contained an *AFC Licensing Division- Incident/Accident Report* that documented that the incident occurred on 06/25/2024 at 7pm. The document was authored by DCW Leonard and documented that DCW Ramirez and DCW McGovern were the direct care workers on duty at the time of the incident. In the "explain what happened" section of the report it stated:" Staff was assisting [Resident A] into her room. Her right foot hit the doorway while turning into the room. Staff noticed slight swelling and applied ice to her foot and gave her Tylenol for possible pain." In the "action taken by staff" section of the report it stated: "Management notified, ice was applied to her foot and Tylenol given for possible pain." On 6/26/2024 the evening staff noticed bruising on her foot, contacted management and was advised to take her into ER. X-rays were taken and results were negative for any fracture." In the" Corrective measures taken to remedy and/or prevent reoccurrence" section of the report stated, "Staff will follow ER discharge recommendations, continue to monitor her for any worse symptoms or sign of increasing pain." In the "physician diagnosis" section of the report it documented "sprain."

I reviewed the *After Visit Summary* that was dated 6/26/2024 which documented that Resident A was evaluated for right foot pain, x-rays completed and instructions are to take Tylenol and Motrin as needed for pain, ice and elevate often.

I reviewed Resident A's *Health Care Chronical* log which documented:

- 06/25/2024, "Hit right foot on door frame when going into her room. Iced 15 minutes on 15 minutes off x2. PRN Tylenol and acetaminophen (2) given for any pain." Signed by DCW Ramirez.
- 6/26/2024, "Took Resident A to the ER for because her right foot was swollen and bruised badly. When she tried to put weight on it she cried and tried putting herself on the floor. The ER took x-rays. When the physician looked the films he didn't see any obvious breaks. Radiology was really behind and will call if there is something that the physician missed." Signed by DCW McGovern.
- 06/27/2024, "8am Motrin given, 5:30pm, acetaminophen given."
- 06/29/2024, "7am ibuprofen given, 12pm, acetaminophen given."

I reviewed Resident A's written *Assessment Plan for AFC Residents*, completed on 01/22/2024, and documented in the "communicated needs" section of the report, "nonverbal but uses body language facial expressions and vocal sounds." In the "walking/mobility" section of the report it stated, "non-ambulatory, uses wheelchair for mobility."

I interviewed DCW Leonard who reported that DCW Ramirez informed her on 06/25/2024 when she was taking her into her bedroom and she accidentally hit Resident A's foot on the door jamb while making the turn. DCW Leonard reported that although Resident A was not wearing her AFO braces at the time that they do cause bruising so it is not abnormal to see bruising on Resident A's feet and ankles. DCW Leonard reported that DCW Ramirez assessed Resident A and there was no apparent injury so she applied ice and administered Resident A Tylenol. DCW Leonard reported that although Resident A is nonverbal, she can communicate with staff and express when she is in pain. DCW Leonard reported that the night Resident A's foot hit the door jamb, Resident A did not express that she was in any pain. DCW Leonard reported that on 06/26/2024 around 1pm DCW McGovern observed Resident A's foot to be swollen and although she was not expressing that she was in pain, Resident A was taken to the emergency department for evaluation. DCW Leonard reported x-rays were taken and the results were negative for any fracture/break. DCW Leonard reported that Relative A1 is going to purchase Resident A bigger shoes as she is worried that with the AFO braces Resident A's shoes are too tight causing the bruising on Resident A's feet. DCW Leonard reported that DCW Ramirez has worked at the facility for a couple of years, she is good staff member and cares for all of the residents. DCW Leonard reported that DCW Ramirez would never do anything to harm a resident. DCW Leonard reported that Resident A is in the first bedroom and that turn in a wheelchair can be tight.

DCW Tosha Parks and DCW Keri Bennett both reported that they worked on 06/26/2024 and DCW Ramirez told them about how Resident A's foot hit the door jamb the night prior. DCW Parks and DCW Bennett both reported that DCW Ramirez worked alone the evening of 06/25/2024 when the accident occurred. DCW Parks reported being responsible for Resident A's care on 06/26/2024 and she did report that Resident A's foot was bruised but the bruising did not seem any different from the bruising from the AFO braces. DCW Bennett reported that DCW Ramirez kept Resident A's foot elevated and iced throughout the night. DCW Parks and DCW Bennett both reported that Resident A was not acting any different nor did she did cry out in pain throughout the day. DCW Parks and DCW Bennett both reported that Resident A does not ambulate on her own. DCW Parks and DCW Bennett both reported that they have worked with DCW Ramirez and that she is a good employee who would never do anything to hurt any resident.

On 08/21/2024, I reviewed a *Michigan Workforce Background Clearance* for DCW Ramirez which was dated 08/19/2020 and documented that DCW Ramirez is eligible to work in an AFC facility.

On 08/26/2024, APS Hilla reported that he is not substantiating due to lack of evidence of abuse/neglect and therefore he is closing the case.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	I reviewed DCW Ramirez's *Workforce Background Clearance* which was dated 08/19/2020 and documented that DCW Ramirez is eligible to work in an AFC facility therefore there is not enough evidence to establish a violation as DCW Ramirez is suitable to meet the needs of residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

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:	Based on interviews with staff and documentation in Resident A's record, on 06/25/2024 around 7:00pm, Resident A's foot hit against the door jamb while DCW Ramirez took Resident A to her bedroom in a wheelchair. DCW Ramirez stated she assessed Resident A at the time the accident occurred and provided ice and Tylenol/Acetaminophen to her and continued to observe her. Around 1pm on 06/26/2024 DCW McGovern took Resident A to the emergency department because she observed her right foot to be swollen and bruised not because Resident A was complaining of pain. I reviewed documentation that confirmed the emergency department took x-rays and no fractures or breaks were observed. There is not enough evidence to establish a violation as once Resident A's foot was observed to be more swollen and bruised, she was taken to the emergency room for evaluation. Prior to being evaluated at the hospital, direct care workers continued to observe and assess Resident A and provided her with Tylenol and acetaminophen as needed. Everyone interviewed reported that although Resident A is non-verbal, she can communicate her needs to the staff.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:
On 07/09/2024, I conducted an unannounced investigation and I reviewed Resident A's record which contained a written *Assessment Plan for AFC Residents* which was completed on 01/22/2024 and documented in the "special equipment used" section of the report, "wheelchair, shower chair, hospital bed with rails and gait trainer."

Resident A's record did not contain any documentation in writing, by a licensed physician for the reason, authorization and term for her wheelchair.

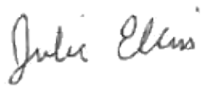
I reviewed Resident A's written *Assessment Plan for AFC Residents* which was completed on 01/22/2024 and documented in the "walking/mobility" section of the report it stated, "non-ambulatory, uses wheelchair for mobility."

On 07/09/2024, at the time of the unannounced investigation I talked with DCW Leonard to determine if there was a physician order for Resident A's wheelchair as could not find it even though I have looked though her entire record. DCW Leonard confirmed that she could not find it but that she would reach out to Community Mental Health (CMH) to see if it could be obtained. I asked DCW Leonard to email the document if it was received. As of the writing of this report the documents have not been received.

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(2) An assistive device shall be specified in a resident's written assessment plan and agreed upon by the resident or the resident's designated representative and the licensee. **(3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the authorization**.
ANALYSIS:	Resident A's written *Assessment Plan for AFC Residents* did not document that she required physician prescribed AFO leg braces therefore a violation has been established. Resident A's record did not contain written physician authorization that contained the reason for the support and the term of the authorization for the wheelchair therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon approval of a corrective action plan, I recommend no change in license status.



08/26/2024

Julie Elkins Date
Licensing Consultant

Approved By:

08/29/2024

Dawn N. Timm Date
Area Manager