GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 21, 2025

Mickey Bauchan
Michigan Community Services, Inc.
PO Box 317
Swartz Creek, MI 48473

RE: License #:	AS250010703
Investigation #:	2025A0123022
	Berneda Home

Dear Mickey Bauchan:

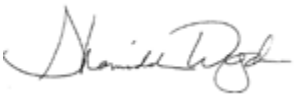
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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) 643-7960.

Sincerely,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250010703
Investigation #:	2025A0123022
Complaint Receipt Date:	02/06/2025
Investigation Initiation Date:	02/07/2025
Report Due Date:	04/07/2025
Licensee Name:	Michigan Community Services, Inc.
Licensee Address:	5239 Morrish Rd. Swartz Creek, MI 48473
Licensee Telephone #:	(810) 635-4407
Administrator:	Sarah Burns
Licensee Designee:	Mickey Bauchan
Name of Facility:	Berneda Home
Facility Address:	5142 Berneda Drive Flint, MI 48506
Facility Telephone #:	(810) 736-5841
Original Issuance Date:	11/02/1983
License Status:	REGULAR
Effective Date:	06/19/2024
Expiration Date:	06/18/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 02/03/2025, staff Tyanna Lang did not use a Hoyer Lift to transfer Resident A. Staff Lang tried to slide Resident A from the bed into the shower chair, but Resident A fell. Staff Lang then called the other staff person on duty to assist. Resident A has a small rug burn like sore on the left knee.	Yes

III. METHODOLOGY

02/06/2025	Special Investigation Intake 2025A0123022
02/06/2025	APS Referral Information received regarding APS referral.
02/07/2025	Special Investigation Initiated - On Site I conducted an unannounced on-site.
02/12/2025	Contact - Telephone call made I interviewed staff Tyanna Lang.
02/12/2025	Contact - Telephone call made I interviewed staff Deidra Palmer.
02/12/2025	Contact - Telephone call made I left a voicemail requesting a return call from Resident A's case manager.
02/12/2025	Contact - Telephone call received I spoke with Resident A's case manager, Linda McNeill.
02/20/2025	Contact- Document Received Received requested documentation.
02/21/2025	Exit Conference With designated person/administrator Sarah Burns.

ALLEGATION: On 02/03/2025, staff Tyanna Lang did not use a Hoyer Lift to transfer Resident A. Staff Lang tried to slide Resident A from the bed into the shower chair, but Resident A fell. Staff Lang then called the other staff person on duty to assist. Resident A has a small rug burn like sore on the left knee.

INVESTIGATION: On 02/07/2025, I conducted an unannounced on-site at the facility. I interviewed home manager Carol Robertson. Staff Robertson was not present during the incident on 02/03/2025. Staff Robertson stated that it was Resident A's shower time. Staff Tyanna Lang tried putting Resident A into a shower chair without a sling, or assistance from staff Deidra Palmer. The shower chair wheels were not locked. Resident A fell on their knees. Staff Palmer had provided Staff Lang with the sling for the Hoyer Lift prior to the incident. Staff Palmer helped Staff Lang get Resident A up from the floor. Resident A's toenail fell off when Resident A fell. Resident A has a toe fungus, and the toenails are brittle. The toenail was going to fall off anyway. Resident A uses a daily fungus cream. Resident A cannot bear weight and is a full assist. Staff Lang is very aware of the facility's procedures and has been employed for at least four of five years. Staff Lang is an emergency relief staff, and primarily works second and third shifts.

During this on-site, I observed Resident A lying in bed. Resident A is non-verbal and could not be interviewed. An abrasion was observed on Resident A's knee. Resident A appeared clean and appropriately dressed. The other residents present in the common areas of the facility were observed as well to be clean and appropriately dressed.

A copy of Resident A's Genesee Health System's *OT* (Occupational Therapy) *Treatment Plan* notes on page three that Resident A is dependent on staff to complete safe transfers, and to reduce the risk of injury staff are to use a mechanical lift or two-person transfer for all transfers. Resident A's *Assessment Plan for AFC Residents* dated 03/18/2024 notes that Resident A uses a shower chair, Hoyer lift and sling as assistive devices.

On 02/12/2025, I interviewed staff Tyanna Lang via phone. She stated that she has been employed with the company for nine years, is an emergency relief staff, and usually only works third shift. Staff Lang stated that it was her first time attempting to transfer Resident A. She was trying to get Resident A into a shower chair. Resident A fell, and Resident A's toenail fell off. The back wheels of the shower chair were not locked, and that is why the chair rolled. Resident A's leg fell, but not their upper body. Resident A's knee hit the floor. Staff Lang stated that she did not know Resident A was a two-person assist, because she usually never works with Resident A. Staff Lang stated that Staff Palmer assisted her with the Hoyer lift and got Resident A into the shower chair. Staff Lang stated that she gave Resident A a shower, then got Resident A back into bed. Staff Lang stated that she also cleaned Resident A's toe with a wound cleaner, applied ointment, and wrapped Resident A's toe.

On 02/12/2025, I interviewed staff Deidra Palmer via phone. Staff Palmer stated that she did not witness Staff Lang drop Resident A. Staff Lang had never previously showered Resident A before, but Staff Lang knew that Resident A requires the use of a Hoyer Lift. Staff Palmer stated that she provided Staff Lang with the Hoyer net, then she left the room. She stated that Staff Lang called out for her, and when Staff Palmer reentered the room, she yelled "*You didn't use the Hoyer net*!" Staff Palmer stated that Staff Lang said she thought she could transfer Resident A like she does with another resident in the home that is a one-person assist. Staff Palmer stated that they did a two-person transfer to get Resident A into the shower chair from the floor. Resident A had an abrasion on the knee. There was blood on the floor from Resident A's toenail falling off. Staff Lang then showered Resident A. After the shower, Staff Lang cleaned and bandaged Resident A's toe. Staff used the Hoyer lift to get Resident A back into bed. Staff Palmer checked Resident A over. Resident A was acting themselves, and there was no sign of pain. Staff Palmer stated that she did not suspect anything to be broken, and she monitored Resident A overnight. That evening, staff Carol Roberston called the facility, and Staff Palmer informed Staff Roberston of the incident. Staff Lang was instructed to write an incident report. Staff Palmer stated that Staff Lang usually works third shifts, but knows Resident A is a Hoyer lift. All four wheels on the shower chair were not locked. It is in Resident A's plan that if a Hoyer lift is not available, Resident A is to be a two-person assist. The incident occurred around 8:00 pm. Staff Robertson stated that Resident A's knee and toe looks a lot better now.

On 02/12/2025, I spoke with Resident A's case manager Linda McNeil of Genesee Health Systems via phone. Linda McNeil stated that she was informed about the situation with Resident A. She stated that she is a new case manager to Resident A as of 02/01/2025. She stated that as far as she knows this was the first occurrence where a staff person had an incident like this with Resident A. Linda McNeil stated that appropriate action was taken by the home. The guardian, recipient rights, etc. were contacted and informed. Linda McNeil stated that she has conducted about two or three visits at the facility, and each time staff were observed to be wonderful with Resident A. She denied having any other concerns.

On 02/20/2025, I received a copy of the *AFC Licensing Division- Incident/Accident Report* dated 02/03/2025 at 8:15 p.m. It notes the following:
Explain What Happened/ Describe Injury (if any): "*Transferring from bed to chair [Resident A's] leg dropped. Called staff to help get legs chair back wheel wasn't lock one so it was hard for both us got [Resident A] up chair shower cleaned wound & lifted [Resident A] back in bed*." *Action taken by Staff/Treatment Given:* "*Clean up & covered it, call manager*" *Corrective Measures Taken to Remedy and/or Prevent Recurrence*: "*All transfers are to be done with hoyer lift. Continue to follow IPOS, and health & safety. Monitor knee and toe for healing. (During the fall head, back, neck were not hit or injured*."

Attached to the incident report was a document entitled *Disciplinary Action Form* dated 02/03/2025, and signed on 02/19/2025 by administrator Sarah Burns and Staff

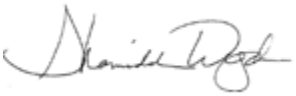
Lang. In summary it states that Staff Lang transferred Resident A from the bed to shower chair without using the Hoyer lift. The shower chair moved from under Resident A, and Resident A fell to the floor landing on (Resident A's) knees. Resident A's right big toe came off, and there was a left knee rug burn. Staff Lang was in-serviced on Hoyer lift use and is expected to use a Hoyer lift for every transfer for any resident that requires it. It also notes that recurrence will result in termination.

On 02/21/2025, I conducted an exit conference with designated person and administrator Sarah Burns. I informed Sarah Burns of the findings and conclusion. Sara Burns stated that they are currently working in-servicing all staff on Hoyer lift usage.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	On 02/07/2025, I conducted an unannounced on-site at the facility. During this on-site, I observed Resident A lying in bed. An abrasion was observed on Resident A's knee. Resident A could not be interviewed due to being non-verbal. During the course of this investigation, I interviewed home manager Carol Robertson, staff Tyanna Lang, and staff Deidra Palmer. They all reported that staff Tyanna Lang did not use a Hoyer lift to transfer Resident A, which led to Resident A having an abrasion on the knee, and toenail falling off. On 02/12/2025, I spoke with Resident A's case manager Linda McNeil. She stated that she was informed of what occurred, and as far as she knows this was the first incident staff did not appropriately transfer Resident A. On 02/20/2025, I received a copy of the incident report and disciplinary action documentation for Staff Lang that confirms Resident A was not transferred appropriately with a Hoyer lift. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

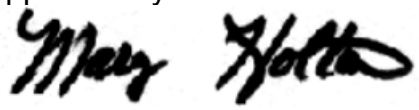
Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC small group home license (capacity 3-6).



02/21/2025

Shamidah Wyden Date
Licensing Consultant

Approved By:



02/21/2025

Mary E. Holton Date
Area Manager