GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 1, 2019

Cathy McCowan
Able Manor LLC
5221 Westview
Clarkston, MI 48346

RE: License #: AS630288437
Investigation #: 2019A0993047
Able Manor

Dear Ms. McCowan:

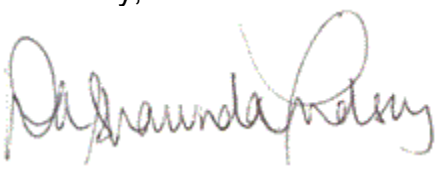
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 505-8036

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630288437
Investigation #:	2019A0993047
Complaint Receipt Date:	07/18/2019
Investigation Initiation Date:	07/23/2019
Report Due Date:	09/16/2019
Licensee Name:	Able Manor LLC
Licensee Address:	5221 Westview Clarkston, MI 48346
Licensee Telephone #:	(248) 599-9407
Administrator:	Jamie Davis
Licensee Designee:	Cathy McCowan
Name of Facility:	Able Manor
Facility Address:	5221 Westview Clarkston, MI 48346
Facility Telephone #:	(248) 599-9407
Original Issuance Date:	03/17/2008
License **Status:**	REGULAR
Effective Date:	09/14/2018
Expiration Date:	09/13/2020
Capacity:	6
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
On 07/12/2019, at around 6am, Resident B left her bedroom to use the bathroom unassisted. She fell in the bathroom, called for help and waited 30 minutes for help. Staff were aware of Resident B's shakiness and decreased mobility.	Yes

III. METHODOLOGY

07/18/2019	Special Investigation Intake 2019A0993047
07/23/2019	APS Referral Allegations reported to adult protective services (APS)
07/23/2019	Special Investigation Initiated - Telephone Telephone call made to Resident B's power of attorney (and brother). Left a message.
07/23/2019	Contact - Telephone call received Telephone call received from Resident B's power of attorney (and brother)
07/24/2019	Inspection Completed On-site Conducted an announced onsite investigation
07/24/2019	Contact - Face to Face Interviewed Resident B at her current residence
07/24/2019	Contact - Telephone call made Telephone call made to staff Jimmie McCowan
07/24/2019	Contact - Telephone call made Telephone call made to APS specialist Shauna Alfred
07/25/2019	Contact - Telephone call received Telephone call received from APS specialist Shauna Alfred
07/30/2019	Exit Conference Exit conference with licensee designee Cathy McCowan

ALLEGATION:

On 07/12/2019, at around 6am, Resident B left her bedroom to use the bathroom unassisted. She fell in the bathroom, called for help and waited 30 minutes for help. Staff were aware of Resident B's shakiness and decreased mobility.

INVESTIGATION:

On 07/18/2019, I received the allegations from Bureau of Child and Adult Licensing (BCAL) Online Complaints. On 07/23/2019, I forwarded the allegations to adult protective services (APS).

On 07/23/2019, I conducted a telephone interview with Resident B's power of attorney (and brother) and Resident B's sister-in-law. They stated Resident B moved into the facility on 06/30/2019. Staff noticed a decrease in her mobility and began using a wheelchair to move her around the facility. Staff notified Resident B's family of Resident B's wheelchair usage, shakiness and decreased mobility on 07/09/2019. On 07/12/2019, around 6am, Resident B left her bedroom to use the bathroom unassisted. She fell in the bathroom, called for help, but waited 30 minutes for assistance. Staff notified Resident B's family of the fall around 9am that day. When Resident B's sister-in-law arrived at the facility, she requested that 911 was contacted. An ambulance was called around 10:30am. Resident B was taken to St. Joseph Mercy Hospital. She sustained a broken hip and fractured neck. EMS personnel informed Resident B's family and staff that Resident B should have been sent to the emergency room immediately after the fall due to her being on blood thinners.

On 07/24/2019, I conducted an onsite investigation. I interviewed staff Vickie Sumner. Ms. Sumner stated she was not working in the facility at the time Resident B fell in the bathroom on 06/04/2019. When Ms. Sumner arrived at the facility, staff Jimmie McCowan informed her Resident B had fallen earlier that morning. Ms. Sumner did not know what time Resident B fell. She checked on Resident B and she appeared to be in pain. She asked Resident B about her pain, but she did not tell her where she was hurting. Ms. Sumner contacted Resident B's sister-in-law to informed her of Resident B's fall and her condition at that time. When Resident B's sister-in-law arrived at the facility, she requested Ms. Sumner to contact 911. Resident B was taken to St. Joseph Mercy Hospital. Ms. Sumner verified EMS personnel stated Resident B should have been sent to the emergency room immediately after the fall due to her being on blood thinners. Resident B's sister-in-law contacted staff and stated Resident B sustained a broken hip. Resident B went to rehabilitation facility after she was discharged from the hospital.

Ms. Sumner verified Resident B began requiring a walker and wheelchair while in the facility as she began shaking a lot and was becoming weaker. According to Ms. Sumner, staff were not required to assist Resident B with toileting. In addition, Resident B did not require line of sight supervision and/or within arm's reach of staff.

During the onsite investigation, I reviewed Resident B's assessment plan. Per the plan, Resident B had a walker and wheelchair. Her walking/mobility was "unsteady;" however, she was able to walk short distances. Resident B required assistance with bathing, grooming and dressing. She did not require assistance with toileting.

On 07/24/2019, I attempted to interview Resident B at her current residence. Resident B's power of attorney (and brother) was present during the interview. I was only able to obtain limited details due to Resident B's cognitive state. Resident B stated she fell when she went to the bathroom. She asked staff for assistance. She waited a couple of hours in the bathroom before staff came. EMS personnel picked her up from the bathroom floor and took her to the hospital.

Resident B's power of attorney (and brother) stated he did not know how long Resident B waited on the bathroom floor; however, he stated when he initially asked Resident B, she stated it was 30 minutes. In addition, staff assisted Resident B off the floor and assisted her back bedroom. EMS personnel transported her from her bedroom to the hospital.

On 07/24/2019, I conducted a telephone interview with staff Jimmie McCowan. Mr. McCowan verified Resident B fell on the bathroom floor on 06/04/2019 around two to three o'clock that morning. He asked Resident B if she was hurt and Resident B denied being hurt. He stated Resident B did not appear to be in pain. Mr. McCowan cleaned Resident B up and assisted her back to her bedroom. When Ms. Sumner arrived at the facility, he informed her of Resident B's fall. Mr. McCowan then ended his shift.

Mr. McCowan stated he checked on Resident B every 30 to 40 minutes. He verified Resident B began requiring a walker and wheelchair while in the facility as she began shaking a lot and was becoming weaker. In addition, Resident B did not require line of sight supervision and/or within arm's reach of staff.

On 07/30/2019, I conducted an exit conference with licensee designee Cathy McCowan. I informed her of the findings. She agreed to submit a corrective action plan.

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: (a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.

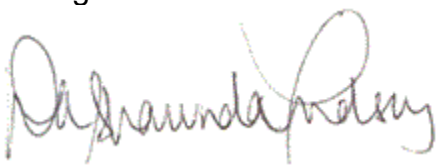
ANALYSIS:	Resident B was admitted into the facility on 06/30/2019. After being admitting into the facility, Resident B began requiring a walker and wheelchair more as she began shaking a lot and was becoming weaker. It appeared that Resident B required more personal care, protection and supervision. Resident B's assessment plan was not updated to reflect that.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Per Resident B's assessment plan, Resident B had a walker and wheelchair. Her walking/mobility was "unsteady;" however, she was able to walk short distances. Resident B required assistance with bathing, grooming and dressing. She did not require assistance with toileting. Staff were following Resident B's assessment plan as written.
CONCLUSION:	VIOLATION NOT ESTABLISHED

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:	Resident B fell in the bathroom around 2 to 3 o'clock in the morning on 06/04/2019. Resident B was not sent to the emergency room until after 10:30am. Resident B is on a blood thinner. Due to being on a blood thinner, Resident B should have been sent to the emergency room immediately after her fall.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

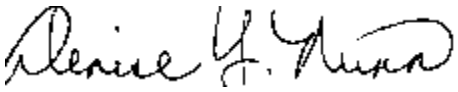
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.



07/31/2019

DaShawnda Lindsey — Date
Licensing Consultant

Approved By:



08/01/2019

Denise Y. Nunn — Date
Area Manager