GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 8, 2021

Patricia Roberts
Summers Living System Inc
PO Box 642
Flushing, MI 48433-0642

RE: License #: AS250010885
Investigation #: 2021A0569015
Shumpert Home

Dear Ms. Roberts:

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 (810) 787-7031.

Sincerely,

Kent W Gieselman, Licensing Consultant
Bureau of Community and Health Systems
4809 Clio Road
Flint, MI 48504
(810) 931-1092

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250010885
Investigation #:	2021A0569015
Complaint Receipt Date:	02/23/2021
Investigation Initiation Date:	02/23/2021
Report Due Date:	04/24/2021
Licensee Name:	Summers Living System Inc
Licensee Address:	5514 W Vienna Rd Clio, MI 48420
Licensee Telephone #:	(810) 640-8740
Administrator:	Patricia Roberts
Licensee Designee:	Patricia Roberts
Name of Facility:	Shumpert Home
Facility Address:	5514 W. Vienna Rd. Clio, MI 48420
Facility Telephone #:	(810) 687-4800
Original Issuance Date:	07/17/1989
License Status:	REGULAR
Effective Date:	07/18/2020
Expiration Date:	07/17/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A was found to be injured on 2/22/2021. She had pain in her leg and would not stand on it. She currently has three subdural hematomas, a broken left clavicle, and fractured ribs.	Yes

III. METHODOLOGY

02/23/2021	Special Investigation Intake 2021A0569015
02/23/2021	APS Referral Referral received from APS.
02/23/2021	Special Investigation Initiated - Letter Email from Matt Potts, RRO.
02/23/2021	Contact - Document Received IR received from Licensee.
03/29/2021	Contact - Document Received received investigation report from Matt Potts.
04/07/2021	Contact- Telephone call made. Contact with Connie Kale, GHS case manager.
04/07/2021	Inspection Completed On-site
04/07/2021	Inspection Completed-BCAL Sub. Compliance
04/07/2021	Exit Conference Exit conference with Jamaica Roberts, home manager.

ALLEGATION:

Resident A was found to be injured on 2/22/2021. She had pain in her leg and would not stand on it. She currently has three subdural hematomas, a broken left clavicle, and fractured ribs.

INVESTIGATION:

This complaint was received from the adult protective services central intake department. The complainant reported that Resident A was treated at the hospital on 2/22/21 for several injuries including subdural hematomas, broken left clavicle, and fractured ribs. The complainant reported that the staff at this facility reported that Resident A had a “hard fall” at the facility.

An incident report was submitted to the department on 2/23/21. The incident report documents that Resident A was “standing in the walkway by the steps and was verbally prompted to go sit down on the couch”. The incident report documents that Resident A then started running towards the couch and her foot caught the end table and she fell on her left side. The incident report documents that the staff then helped Resident A up and laid her on the couch. The staff then gave Resident A Tylenol and let Resident A sleep on the couch to monitor her throughout the night. The incident report was completed by Arianna Wright, staff person.

Matt Potts, recipient rights officer, submitted an investigative summery on 3/29/21. Mr. Potts’ report documents that Resident A’s fall was accidental, but that Resident A fell at approximately 9:00pm on 2/21/21 witnessed by Arianna Wright, staff person. Mr. Potts’ report also documents that Resident A was not taken for medical treatment until the next morning, 2/22/21, after Jamaica Roberts, home manager, arrived at the facility. Mr. Potts substantiated that Resident A’s medical needs were neglected by the staff and recommended that Arianna Wright, staff person, receive a two-week suspension.

Ariana Wright stated on 2/23/21, that she arrived for her shift at about 6:00pm on 2/21/21. Ms. Wright stated that at about 9:00pm, Resident A was standing near the entry way to the living room and suddenly began running towards Ms. Wright, which is typical behavior for Resident A. Ms. Wright stated that Resident A frequently runs around the facility. Ms. Wright stated that as Resident A was running, her foot caught a leg on the table and due to Resident A’s momentum, she “fell hard” on her left side. Ms. Wright stated that Resident A did not put her hands out to break her fall, and Resident A took the “full impact” of the fall to the left side of her head and body. Ms. Wright stated that she immediately went to assist Resident A up, but Resident A did not act like she wanted to get up off of the floor. Ms. Wright stated that Resident A is non-verbal. Ms. Wright stated that she then got Resident A up and onto the couch where she sat for about five minutes. Ms. Wright stated that Resident A then got back onto the floor and laid down which is unusual behavior for her. Ms. Wright stated that she thought that Resident A may be in pain, so she gave Resident A Tylenol and had her lie back on the

couch. Ms. Wright stated that she had Resident A sleep through the night on the couch so that she could monitor Resident A more closely. Ms. Wright stated that when Resident A got up the next morning, she did not seem to want to walk or stand and seemed to be favoring her left side. Ms. Wright stated that she never called management and did not seek medical attention for Resident A even though Resident A seemed to be in pain.

An unannounced inspection of this facility was conducted on 4/7/21. Resident A has been moved to another facility and is non-verbal so she could not be interviewed. Jamaica Roberts, home manager, stated that she arrived at the facility at about 6:00am on 2/22/21. Ms. Roberts stated that after she arrived, Ms. Wright informed her that Resident A had fallen the night before and seemed to be in pain. Ms. Roberts stated that Resident A was sleeping on the couch when she arrived, and when Resident A woke up, she tried to help Resident A up off of the couch. Ms. Roberts stated that Resident A acted like she was hurting and would not put weight on her left leg or walk. Ms. Roberts stated that she then took Resident A to the hospital for medical attention at about 9:00am on 2/22/21. Ms. Roberts stated that she did do a “body check” of Resident A when she woke up and that she did not observe any bruising on Resident A’s body. Ms. Roberts stated that she learned of the extent of Resident A’s injuries after she was examined at the hospital.

Connie Kale, Resident A’s GHS case manager, stated on 4/7/21 that Resident A is currently in the hospital again due to issues with her feeding tube and that Resident A has also tested positive for COVID-19. Ms. Kale stated that she does believe that Resident A’s injuries are accidental as Resident A has a long history of “bolting suddenly” and running around the facility. Ms. Kale stated that Resident A has resided at this facility since 1995 and that she has not sustained injuries like this prior to this incident. Ms. Kale stated that Resident A was moved to a more “barrier free” facility due to her running behaviors. Ms. Kale stated that she has never observed Resident A to be uncared for when she has visited Resident A and that Resident A was always appropriately dressed and groomed. Ms. Kale stated that Resident A is non-verbal, but that Resident A has never exhibited any behaviors indicating that she was fearful of any of the staff. Ms. Kale stated that Resident A was fully ambulatory at the time of this accident and had a normal gait without staff assistance. Ms. Kale stated that she did not have any further concerns regarding Resident A’s direct care while she was living at this facility.

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:	Ms. Wright and Ms. Roberts both stated that Resident A fell while running in the facility on 2/21/21. Ms. Wright described the fall as a “hard fall” and Resident A landed on her left side. Ms. Wright admitted that Resident A exhibited behaviors that made he believe that Resident A was in pain, but that she laid Resident A on the couch and gave her Tylenol then allowed Resident A to sleep on the couch. Ms. Roberts stated that she was informed of Resident A’s fall when she arrived at the facility on 2/22/21 and that Resident A was acting like she was in pain and would not put weight on her left leg. The complainant and Mr. Potts stated that Resident A had sustained two subdermal hematomas, broken ribs, and a broken clavicle as a result of this fall. According to Ms. Wright and Ms. Roberts statements, Resident A fell at about 9:00pm on 2/21/21 and was not taken to the hospital for treatment until about 9:00am on 2/22/21. Based on the statements given and documentation reviewed, it is determined that there has been a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

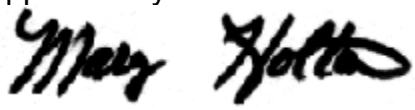
IV. RECOMMENDATION

I recommend that the status of this license remain unchanged with the receipt of an acceptable corrective action plan.

4/8/21

Kent W Gieselman — Date
Licensing Consultant

Approved By:



4/8/21

Mary E Holton — Date
Area Manager