GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 23, 2022

Gagandeep Mann
JP Managed Services, Inc.
Suite A
2316 John R
Troy, MI 48083

RE: License #: AL630295441
Investigation #: 2022A0465012
Sun Valley Senior Living

Dear Ms. Mann:

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:

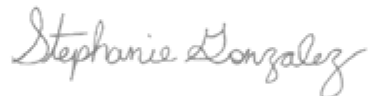
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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,



Stephanie Gonzalez, LCSW
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enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630295441
Investigation #:	2022A0465012
Complaint Receipt Date:	01/05/2022
Investigation Initiation Date:	01/05/2022
Report Due Date:	03/06/2022
Licensee Name:	JP Managed Services, Inc.
Licensee Address:	Suite 3 - 2710 Rochester Road Rochester Hills, MI 48307
Licensee Telephone #:	(248) 497-4391
Administrator:	Gagandeep Mann
Licensee Designee:	Gagandeep Mann
Name of Facility:	Sun Valley Senior Living
Facility Address:	2316 John R Troy, MI 48084
Facility Telephone #:	(248) 689-7755
Original Issuance Date:	09/13/2010
License Status:	REGULAR
Effective Date:	12/22/2021
Expiration Date:	12/21/2023
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 1/4/2022, direct care staff did not provide adequate safety and protection to Resident A. Resident A wandered to the second floor and fell off of the second-floor balcony onto the concrete sidewalk	Yes

III. METHODOLOGY

01/05/2022	Special Investigation Intake 2022A0465012
01/05/2022	Special Investigation Initiated – Document Sent Spoke to Complainant via email exchange
01/05/2022	APS Referral Adult Protective Services (APS) referral was denied and referred to LARA for investigation
01/05/2022	Contact - Telephone Spoke to Detective Whiteside
01/07/2022	Inspection Completed On-site
01/07/2022	Contact - Document Received Received Troy Police Department report
01/10/2022	Contact - Document Received Facility documents received from facility
01/14/2022	Contact - Telephone call made Spoke to Guardian A1
02/09/2022	Contact - Document Received Facility documents received
02/28/2022	Contact - Telephone call made Interviewed direct care staff, Desirae Peters

02/28/2022	Contact - Telephone call made Attempted to contact direct care staff, Jessica Fountain. No return call received.
03/07/2022	Inspection Completed-BCAL Sub. Non-Compliance
03/07/2022	Exit Conference Conducted an Exit Conference with Gagandeep Mann

ALLEGATION:

On 1/4/2022, direct care staff did not provide adequate safety and protection to Resident A. Resident A wandered to the second floor and fell off of the second-floor balcony onto the concrete sidewalk.

INVESTIGATION:

On 1/5/2022, a complaint was received alleging that on 1/4/2022, direct care staff did not provide adequate safety and protection to Resident A. The complaint indicated that Resident A has a medical diagnosis of Dementia. On 1/4/2022, the door that leads to the second floor was left unlocked. Subsequently, Resident A wandered to the second floor and fell off of the second-floor balcony onto the concrete sidewalk. A public citizen was driving by, observed Resident A hanging from the balcony and contacted law enforcement. The Troy Police Department and paramedics responded to the facility, at which time law enforcement knocked on the facility's front door to notify the direct care staff of the incident. Direct care staff were not aware that Resident A was missing or had been injured until notified by law enforcement.

On 1/5/2022, I spoke to Complainant, who confirmed that the information contained in the complaint is accurate.

On 1/5/2022, I spoke to Troy Police Department detective, Ryan Whiteside. Detective Whiteside stated that there will not be any criminal charges filed at this time. Mr. Whiteside emailed me a copy of the completed police report. The police report indicated the following:

> On 1/4/2022, at approximately 4:09pm, Officers Lane, Daniels and O'Brien were dispatched to Sun Valley Senior Living for Resident A, that had fallen from a second-floor balcony onto the concrete below. Public Citizen 1 was driving northbound on John R when they observed Resident A with one leg over the top railing of the balcony. By the time the caller turned around, Resident A had fallen. Officer Lane was first on the scene and observed Resident A was conscious and breathing. Public Citizen 1 turned around while her son called 911. Public Citizen 1 went to the facility and banged on the locked front door to notify staff, Desirae Peters and Jessica Fountain. The building layout includes a staircase that leads to a second-floor apartment. A flimsy, plastic, piece of lattice is placed between the banister slats to block residents from climbing the stairs. This makeshift barrier is unsecured and easily pushed flat with minimal effort. There is a door at

the top of the stairs with a keyed lock. The balcony is accessed from inside the second-floor apartment. Ms. Peters was interviewed and stated she was temporarily living the second-floor apartment. Ms. Peters stated she went downstairs to use the fax machine and did not realize she had not locked the door at the top of the stairs. Ms. Peters stated she was not "on the clock" at the time of this incident and did not hear or see Resident A exit her bedroom. Jessica Fountain was the caretaker on duty and stated she did not see Resident A leave her room or hear the door chime that is supposed to ring when the door opens. Resident A was transported to Beaumont by Alliance. APS notified.

On 1/7/2022, I conducted an onsite investigation at the facility. The facility specializes in the Aged/Alzheimer's population. At the time of the onsite investigation, there were nine residents residing in the facility and Resident A was no longer residing at the facility. I conducted a walkthrough of the facility and reviewed Resident A's record. Upon entering the facility, I observed the stairway leading to the second floor. At the bottom of the stairs was a plastic piece of lattice between the banister slats. The lattice was not secured, and I was able to easily move it and step over it to gain access to the stairway. At the top of the stairs, I observed a door with a keyed lock. The door was locked, and I was unable to gain access to the second floor without staff assistance. The Face Sheet stated that Resident A was admitted to the facility on 4/22/2021 and has a legal guardian, Guardian A1. The Health Care Appraisal listed Resident A's medical diagnosis as dementia. The Assessment Plan for AFC Residents stated that Resident A needs assistance with bathing, grooming, dressing, personal hygiene and uses a walker for mobility assistance. The Incident/Accident Report dated 1/4/2022, stated the following:

> 1/4/2022 at 4:10pm; Completed by Ms. Fountain: I was walking down the hallway when I heard a banging on the front door. Public Citizen 1 said Resident A went over the balcony. I opened the door, then yelled to Desirae Peters that Resident A was out front. Public Citizen 1 was on the phone with 911. I grabbed a blanket to cover Resident A with. I stayed with Resident A and make sure she stayed calm and didn't move until EMS arrived. Resident A was transported to the hospital by EMS for needed care. Upon release from hospital, discharge instructions will be reviewed accordingly. The apartment will be locked. We are updating our camera system. Stairs will be blocked, so no one is able to climb over.

On 2/28/2022, I interviewed direct care staff, Ms. Desirae Peters. Ms. Peters stated that she has worked at the facility for seven years. Ms. Peters stated, "The upstairs area of the facility is unoccupied. It is not licensed for adult foster care, and no one lives upstairs. The door leading to the second floor is normally always locked. But I stayed upstairs for three days because I had a family member with COVID, and I didn't want to risk getting any of the resident's sick. I was not working at the time of the incident, but I was here in the facility. I was upstairs and came downstairs to the office to use the fax machine. I was in the office for about 10 minutes. I didn't lock the door that leads to the 2nd floor but didn't realize it. The stairs were also not barricaded because I was only going to be downstairs for a few minutes. I did not see Resident A leave her bedroom or go upstairs. Jessica Fountain was the direct care staff on duty at the time of the incident. At the time that Resident A had wandered to the 2nd floor, Ms. Fountain was

helping another resident. Resident A does have a history of wandering. I heard the doorbell ring and when we answered the door, Public Citizen 1 told us that Resident A had climbed onto the balcony and jumped off. We stayed with Resident A until the ambulance arrived and transported her to the hospital. We have installed a new gate at the bottom of the stairs and upgraded the lock keypad system for the door that leads to the 2nd floor, to prevent this from happening again." Ms. Fountain stated that direct care staff, Ms. Fountain, is currently in the hospital and unable to be interviewed for this investigation.

On 1/14/2022, I interviewed Guardian A1, who reported that she is has been the legal guardian for Resident A for several years. Guardian A1 stated, "Resident A is mobile and able to walk around. Resident A has a history of wandering and direct care staff care are aware of this information. Resident A is currently still in the hospital and her injuries are substantial. Resident A has a fractured fibula, compression fracture in her back which requires her to wear a back brace, a large laceration across her left breast and multiple areas of bruising across her body." Guardian A1 stated that she will not be allowing Resident A to return to the facility. Guardian A1 vocalized significant concerns related to Resident A's injuries and the lack of supervision provided to ensure that Resident A's safety and protection needs were met.

Due to Resident A's medical diagnosis of dementia, she was not interviewed as part of this investigation.

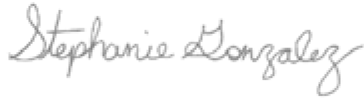
On 3/7/2022, I conducted an exit conference with licensee designee and administrator, Gagandeep Mann. Ms. Mann is in agreement with the findings in this report and is in agreement with the issuance of a six-month provisional license.

APPLICABLE RULE	
R 400.15305	**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 1/4/2022, Ms. Peters left the 2nd floor entry door unlocked and unattended for approximately 10 minutes. During which time, Resident A was unsupervised and able to enter the 2nd floor living area. Resident A subsequently fell off the 2nd floor balcony and sustained multiple bone fractures, bruising and one large laceration. According to the *Incident/Accident Report* and Ms. Peters, Ms. Fountain was on duty at the time of the incident and did not hear the door alarm chime, which is intended to alert staff when a resident is attempting to enter the 2nd floor area. Ms. Peters was in the facility at the time of the incident but was not on duty. Ms. Peters did not observe Resident A leave her bedroom and walk

	up the stairway to the 2nd floor. Ms. Peters and Ms. Fountain were not aware that Resident A had left her bedroom and had fallen from the balcony until notified by Public Citizen 1. Based on the information above, the facility did not ensure Resident A's personal needs, including safety and protection were attended to on 1/4/2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that a six-month provisional license be issued.



3/10/2022

Stephanie Gonzalez Date
Licensing Consultant

Approved By:

03/23/2022

Denise Y. Nunn Date
Area Manager