GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 4, 2022

Brenda Kirtley
Meadows by the Lake Inc.
PO Box 213
Stanton, MI 48888

RE: License #: AL590404706
Investigation #: 2022A1029022
Meadows by the Lake

Dear Ms. Kirtley:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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 (231) 922-5309.

Sincerely,

Jennifer Browning

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
Browningj1@michigan.gov - (989) 444-9614

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL590404706
Investigation #:	2022A1029022
Complaint Receipt Date:	01/07/2022
Investigation Initiation Date:	01/07/2022
Report Due Date:	03/08/2022
Licensee Name:	Meadows by the Lake Inc.
Licensee Address:	731 S. Nevins Road, Stanton, MI 48888
Licensee Telephone #:	(616) 894-8198
Administrator:	Brenda Kirtley
Licensee Designee:	Brenda Kirtley
Name of Facility:	Meadows by the Lake
Facility Address:	904 Oak Drive, Greenville, MI 48838
Facility Telephone #:	(616) 894-8198
Original Issuance Date:	09/24/2021
License Status:	TEMPORARY
Effective Date:	09/24/2021
Expiration Date:	03/23/2022
Capacity:	16
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED ALZHEIMERS

ALLEGATION(S)

	Violation Established?
Resident A was not provided treatment after slipping on the floor in the bathroom.	No

II. METHODOLOGY

01/07/2022	Special Investigation Intake 2022A1029022
01/07/2022	Special Investigation Initiated – Telephone to complainant for more information
01/12/2022	Contact - Document Received - IR for the falls.
01/13/2022	Contact - Telephone call made to Relative A1
01/13/2022	Contact - Face to Face with Brenda Kirtley at Meadows by the Lake
01/27/2022	Contact - Telephone call received to Brenda Kirtley
02/22/2022	Contact - Telephone call made to Maggie Botek
02/23/2022	Contact – Face to face with direct care staff members Jessica Warner and Debbie Sharpe, Maggie Botek, Licensee designee, Brenda Kirtley at Meadows by the Lake.
02/25/2022	Contact – Telephone call to Dr. Gretchen Schumacher PhD, NP from Elder Care of West Michigan.
02/25/2022	Exit conference with Licensee designee, Brenda Kirtley.

ALLEGATION:

Resident A was not provided treatment after slipping on the floor in the bathroom.

INVESTIGATION:

On January 7, 2022, a complaint was received stating that Resident A slipped on water in the bathroom and then later on January 7, 2022 fell out of bed due to pain and had to be taken to the hospital. There were concerns that no one was assisting Resident A while she was in the bathroom leading to the fall and concerns that she did not receive

medical attention after the incident.

On January 7, 2022, I contacted Complainant who reported Resident A was admitted to Spectrum Health Butterworth Hospital. Complainant stated Resident A was told by facility direct care staff that if she had been wearing socks, she would not have fallen. Complainant also alleged facility direct care staff also told Resident A she should have been wearing her call alert button when using the bathroom. Complainant stated Resident A fell the first time in the bathroom and the second time she fell out of bed which was what caused her admittance to the hospital.

The *AFC Incident / Accident Report* from Meadows by the Lake was received for the incident following the second fall sending Resident A to the hospital. The *AFC Incident / Accident Report* listed direct care staff members Maggie Botek and Barbara Gardner as those present during Resident A's fall. The *AFC Incident / Accident Report* form was dated for January 7, 2022 and documented that direct care staff member Barbara Gardner found Resident A on the floor in her room. The *AFC Incident / Accident Report* further documented that Resident A stated she slid off the bed. Her vitals were taken and direct care staff members Maggie Botek and Brenda Kirtley both arrived at the facility to assist. According to the *AFC Incident / Accident Report,* EMS was called due to the pain Resident A was having and she called her family to notify them that she was being sent to the ER.

On January 13, 2022, I interviewed Guardian A1 who stated Resident A fell the first time on January 4, 2022 around 7-8:00 a.m. when she went to use the bathroom at the end of the hallway. Guardian A1 reported that there was water on the floor and Resident A slipped on her bottom. Guardian A1 stated Resident A pushed the call button when she fell and direct care staff member came to assist her. Guardian A1 stated she was not with Resident A or at the facility when this fall occurred rather was told this information by Resident A. Resident A's physician is Dr. Gretchen Shumaker. Guardian A1 went to the facility to see Resident A and noted Resident A was given some Tylenol and Bengay from direct care staff members. Guardian A1 stated the second fall occurred a few days later. Guardian A1 stated that on January 5, 2022, she picked Resident A up for an eye appointment and observed Resident A was moving slower during the appointment but had been up early enough to eat breakfast that day. Guardian A1 reported that on the following day, January 6, 2022, shortly after 6:00 a.m. Resident A slipped to the floor off her bed and EMS was called immediately after her fall leading to her admittance to the hospital. Guardian A1 stated Resident A did not require assistance in the bathroom. At this time, she was taken to the hospital and diagnosed with a compression fracture of T12 but it is unclear which fall this is from according to Guardian A1.

On January 13, 2022, I interviewed licensee designee, Brenda Kirtley at Meadows by the Lake. She stated there were two falls for Resident A. She stated that the first one was in the bathroom and the second one was in her bedroom. Ms. Kirtley stated Resident A had her four wheeled walker with her during the first fall in the resident bathroom. Ms. Kirtley stated when a resident uses the shower the direct care staff

member will shut the door until the resident is finished, then come in and mop the excess water from the floor. Ms. Kirtley stated they are going to work on putting up a better shower curtain system to alleviate water on the floor and will make wet floor signs to put up in front of the bathroom door. Ms. Kirtley stated that after Resident A's fall in the bathroom, she did not have any injuries or complain of pain. Ms. Kirtley stated after direct care staff member, Ms. Warner assisted Resident A, she was checked over for injuries to determine if there were any concerns. Ms. Kirtley stated Resident A was observed to be free of any scrapes or bruises and Resident A continued her day as usual.

I reviewed Resident A's resident record. Resident A's *Assessment Plan* was signed on October 21, 2021 and included documentation that she was able to use the bathroom without assistance. For walking / mobility there is documentation that she walks in the hallways and occasionally will use a walker. She had an order in her resident record that she had a seated walker and used a shower chair when showering. There is also a fall risk assessment that she scored an 11 out of 27. Ms. Kirtley stated she uses this form when someone moves in to assess their fall risk while living at Meadows by the Lake. Resident A's *Health Care Appraisal* documented Resident A as being fully ambulatory and that she also used a walker.

On February 22, 2022, I interviewed direct care staff member, Maggie Botek who confirmed Resident A was in the bathroom on January 4, 2022 when Resident A fell. Ms. Botek stated Resident A was able to use the bathroom without assistance. After the fall, Ms. Botek stated Resident A acted fine and did not act like she was hurt. Ms. Botek stated Resident A walked like she normally did, ate regularly and overall had a normal day. Ms. Botek stated she went into the shower area to assist Resident A after her fall and noted Resident A did not have slippers on her feet. Ms. Botek also stated there was no water on the floor in the shower area or near the toilet when she went in the bathroom to assist Resident A from the bathroom floor. Ms. Botek evaluated her for injuries and Resident A did not complain to be in pain and she did not notice any bruises or injuries on her body. Ms. Botek stated she went to the eye appointment with Guardian A1 and Resident A on January 5, 2022. Ms. Botek did not recall Resident A complaining of any pain during that appointment or not being able to get around during the appointment. Ms. Botek stated she would have documented it if Resident A had complained of any pain. Ms. Botek stated Resident A told her that she was upset with Guardian A1 because Guardian A1 did not feel that she was being cared for and she wanted to take her out of the facility for more outings and home time whereas Resident A wanted to stay at Meadows by the Lake to see her new friends. Ms. Botek stated the morning Resident A slid out of her bed onto the floor, she was not working but came straight to the facility when she heard this occurred. Ms. Botek stated that she and direct care staff member Barbara Gardner did not move Resident A but they stayed by her side making her as comfortable as possible until EMS arrived. Ms. Botek stated she does not believe the two falls are connected.

On February 23, 2022 I interviewed licensee designee Brenda Kirtley at Meadows by the Lake. She showed me the improvements she made to the bathroom area and the

shower curtain that was recently put up with a ledge around the shower area to make sure water does not come out into the main bathroom area. Ms. Kirtley stated they are also now locking the door to ensure that no one is in the bathroom if the floor may be wet. There is also a wet floor sign that will go up. I did not observe any water on the bathroom floor at the time of the investigation. Ms. Kirtley stated she encourages all residents to use the call buttons for assistance first but in this situation it was not used until after Resident A fell because she had the call button on her in the bathroom. Ms. Kirtley stated she does not know if there actually any water on the bathroom floor at the time Resident A was fell while using the toilet but Ms. Kirtley wants to take as much precautions as possible to avoid something like this happening. Ms. Kirtley stated Dr. Gretchen Shumacher from Elder Care of West Michigan was at the home for another resident at the time Resident A fell in the bathroom, so Dr. Shumacher was able to examine Resident A and assess her for injuries but she did not find any injuries. According to Resident A's medication administration record, Resident A received one dosage of PRN Tylenol on January 3, 2022, the day before she fell the first time, and was administered Tylenol as a PRN three times throughout the day on January 6, 2022.

On February 25, 2022, I interviewed direct care staff member Jessica Warner who was present for both of Resident A's falls. Ms. Warner stated Resident A used her call button while she was on the floor in the bathroom. She stated that she and Ms. Kirtley asked Resident A if she was hurt and she said "no." Ms. Warner stated they picked her up after assessing for injuries. After this happened, Resident A was evaluated by Dr. Gretchen Shumacher who was at the facility during the time of the fall. Ms. Warner stated she did not see any water on the bathroom floor at the time Resident A fell but she did notice Resident A was not wearing any shoes or socks and was bare footed. On January 5, 2022, Ms. Warner stated Resident A attended an eye appointment and Ms. Warner did not notice anything different from her behavior or how she was walking. Ms. Warner stated the second fall occurred on January 6, 2022 was while Resident A was in bed. Ms. Warner stated Resident A was lying on top of the blanket and when she tried getting up she slid with the blankets down to the floor. After this incident, Ms. Warner reported Resident A did complain of pain so EMS was called and she was taken to the hospital. Ms. Warner reported Resident A did not return to Meadows by the Lake after this incident. At the time of both falls, Ms. Warner reported Resident A did not need hands on care for toileting but Ms. Warner stated she likes to be nearby in case there is a fall.

On February 25, 2022, I interviewed Dr. Gretchen Shumacher from Elder Care of West Michigan. She reported not having any concerns about the facility or their communication. Dr. Shumacher reported Resident A's first fall was in the bathroom and she did not have any injuries. During her second fall, Dr. Schumacher stated it was reported to her that Resident A's feet were caught up in the blanket causing her to fall off her bed. Dr. Shumacher stated she has had wonderful communication with the direct care staff members and licensee designee Brenda Kirtley. She stated the falls were not out of the ordinary for a resident that was 92 years old. To her knowledge, Dr. Schumacher reported there was no water on the bathroom floor when Resident A fell and Resident A did not require assistance to use the restroom. She was not in the

building when she fell but arrived later in the morning of the first fall and was able to assess that Resident A was not injured during this fall. Dr. Schumacher reported that at the time of Resident A's second fall, Resident A was getting out of bed without assistance to use the restroom. Dr. Shumacher stated from a medical standpoint, she was informed of both falls, felt the staff did a thorough assessment of potential injuries, and there was nothing that needed follow up. She did not write any physician instructions or contacts regarding the fall for Meadows by the Lake from either incident.

APPLICABLE RULE	
R 400.15310	**Resident Health Care**
	(4) In case of an accident or sudden adverse change in resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	There is no indication that the direct care staff members at Meadows by the Lake did not respond appropriately to Resident A's falls. During the first fall on January 4, 2022, the staff assessed her to ensure that she did not have any bruising, cuts, or scrapes. She stated that her back hurt but continued to walk, eat, and resumed her daily activities in a normal fashion. Resident A was also evaluated by a physician after the fall. According to Resident A's medication administration record, she was given Tylenol as a PRN on January 6, 2022. Two days later January 6, 2022, Resident A fell out of the bed, described having back pain, and EMS was contacted immediately. Resident A was taken to the hospital and admitted at that time and will not be returning to Meadows by the Lake. Resident A's primary physician Dr. Gretchen Shumacher from Elder Care of West Michigan did not have any concerns regarding follow through from the facility or their assessment and treatment of Resident A following each fall.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

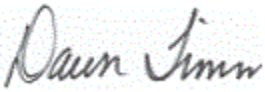
III. RECOMMENDATION

I recommend no change in the license status.

Jennifer Browning
Licensing Consultant

2/25/2022
Date

Approved By:



03/04/2022

Dawn N. Timm
Area Manager

Date