GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 22, 2022

Catherine Reese
Vibrant Life Senior Living OC Temperance, LLC
5720 Williams Lake Road
Waterford, MI 48329

RE: License #: AL580355938
Investigation #: 2022A0116036
Jackman Lodge

Dear Ms. Reese:

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 (313) 456-0380.

Sincerely,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL580355938
Investigation #:	2022A0116036
Complaint Receipt Date:	07/20/2022
Investigation Initiation Date:	07/20/2022
Report Due Date:	09/18/2022
Licensee Name:	Vibrant Life Senior Living OC Temperance, LLC
Licensee Address:	5720 Williams Lake Road Waterford, MI 48329
Licensee Telephone #:	(734) 847-3217
Administrator:	Catherine Reese
Licensee Designee:	Catherine Reese
Name of Facility:	Jackman Lodge
Facility Address:	7342 Jackman Rd Temperance, MI 48182
Facility Telephone #:	(734) 847-4096
Original Issuance Date:	05/09/2014
License **Status:**	REGULAR
Effective Date:	11/09/2020
Expiration Date:	11/08/2022
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Incident report received on 07/19/22, documents at around 12:23 p.m. Resident A asked to go out on the patio. Staff, Osheona Jones, led Resident A outside and went back to check on her at 12:55 p.m. Resident A was outside in the excessive heat and was not checked on again until 4:09 p.m. when the health and wellness director came out of the office and saw her outside. Resident A was unresponsive and 911 was called.	Yes

III. METHODOLOGY

07/20/2022	Special Investigation Intake 2022A0116036
07/20/2022	Special Investigation Initiated - Telephone Interviewed executive director, Rebecca Molina.
07/21/2022	APS Referral Referral Made
08/10/2022	Inspection Completed-BCAL Sub. Compliance Interviewed licensee designee, Catherine Reese, and spoke with Ms. Molina. Reviewed video recording of the incident and reviewed Resident A's records and employee records of the four employees involved.
08/11/2022	Contact - Telephone call made Interviewed former staff, Stephany Duhart.
08/11/2022	Contact - Telephone call made Left a message for former staff, Osheona Jones, requesting a return call.
08/11/2022	Contact - Telephone call made Interviewed former staff, LaQuesha Gilmer.
08/11/2022	Contact - Telephone call made Interviewed former staff, Jacquline Hunter.
08/11/2022	Contact - Telephone call made Interviewed Guardian (1).

08/16/2022	Exit Conference With licensee designee, Catherine Reese.

ALLEGATION:

Incident report received on 07/19/22, documents at around 12:23 p.m. Resident A asked to go out on the patio. Staff, Osheona Jones, led Resident A outside and went back to check on her at 12:55 p.m. Resident A was outside in the excessive heat and was not checked on again until 4:09 p.m. when the health and wellness director came out of the office and saw her outside. Resident A was unresponsive and 911 was called.

INVESTIGATION:

On 07/20/22, I interviewed Rebecca Molina, executive director. Ms. Molina reported that she has conducted an internal investigation into the events that occurred on 07/19/22 and has terminated three of the four employees involved. Ms. Molina reported that there are ongoing discussions to determine if the fourth employee will also be terminated.

Ms. Molina confirmed that after her review of the video footage staff, Osheona Jones and Stephany Duhart were the initial two staff on shift when the incident began. Ms. Molina reported that 07/19/22, was an extremely hot day and reported that, based on the information obtained during the internal investigation, at around 12:23 p.m. Resident A asked Ms. Jones if she could go outside and sit on the patio. Ms. Molina reported according to the video footage Ms. Jones could be seen taking Resident A outside and reported at 12:55 p.m. Ms. Jones went back outside and checked on Resident A who appeared to be fine. Ms. Molina reported that after 12:55 p.m., no one went back outside to check on Resident A until after 4:09 p.m. when Ms. Tyanna Stevenson, assistant wellness director, came out of her office and observed Resident A outside on the patio. Ms. Molina reported that when staff went outside to get Resident A to bring her inside, she was unresponsive and 911 was called. Ms. Molina reported that Resident A also had on a sweatshirt and sweatpants in over 90-degree weather. Ms. Molina reported that it is not uncommon for the residents to have on long sleeve tops and pants in the facility, as they always complain about being cold, however, the fact that Resident A was taken outside on such a hot day in a sweat suit is unacceptable. Ms. Molina added that because of the extremely hot temperature that day, Resident A should have never been taken outside in the first place.

Ms. Molina reported that at 2:45 p.m. two afternoon staff had arrived and reported there were four staff in the building. Ms. Molina reported that the two staff were

Jacquline Hunter and LaQuesha Gilmer. Ms. Molina reported that they were terminated because had they completed their change of shift protocols, which includes them visually checking and changing each resident in the facility, they would have known that Resident A was not in her room or inside the facility. Ms. Molina reported that Ms. Hunter and Ms. Gilmer falsified records by documenting in the computer system that they checked and changed Resident A during the time that she was actually still outside.

Ms. Molina reported that she notified Resident A's guardian of the incident and reported to date she is still hospitalized.

On 08/10/22, I conducted a scheduled onsite at the facility and met with licensee designee, Catherine Reese, and executive director Ms. Molina. Ms. Reese was aware of the incident on the day it occurred and reported taking swift action to terminate the employees involved. Ms. Reese reported that staff Jacquline Hunter was terminated on 07/22/22 for her carelessness involving the incident.

Ms. Reese reported that Resident A's guardian has decided not to return her to the facility, and reported Resident A is home from the hospital and is residing with the guardian.

I observed Resident A's records and reviewed her assessment plan dated 07/06/21. The plan documents that Resident A should avoid extreme temperatures due to her risk of hypothermia and hyperthermia.

I reviewed the employee records of Stephany Duhart, Osheona Jones, LaQuesha Gilmer, and Jacquline Hunter. All of the employees were fully trained in all required areas.

I also reviewed the video footage of the incident which confirmed the events as reported by Ms. Molina.

I was unable to visually observe or interview any residents as the facility is doing some construction/updates to the facility and the residents were admitted to their other two licensed facilities. The residents will move back into this facility upon completion of the work.

On 08/11/22, I interviewed former staff Stephany Duhart. Ms. Duhart confirmed that she was working on the day of the incident. Ms. Duhart reported that she did rounds at about 10:00 a.m. and Resident A was inside and fine. Ms. Duhart reported that she learned after the fact that her co-worker, Ms. Jones had taken Resident A outside around 12:00 p.m.-12:30 p.m. and reported Ms. Jones did not tell her she was taking anyone outside. Ms. Duhart admitted that she made a horrible decision that day, by not checking on all of the residents. Ms. Duhart reported that she did check and change a few of the residents but reported her uber arrived and she left. Ms. Duhart reported that she later received a call from staff Ms. Gilmer telling her

that Resident A was forgotten outside, was unresponsive and in the hospital. Ms. Duhart reported she feels horrible and wishes she would have completed her required checks on each resident, because if she had, Resident A would have been found sooner. Ms. Duhart reported she was terminated and has not returned to the facility since the incident occurred.

On 08/11/22, I interviewed former staff, LaQuesha Gilmer. Ms. Gilmer reported arriving to work at around 3:40 p.m. on 07/19/22, the day the incident occurred. Ms. Gilmer reported she spoke with the 1st shift staff, Stephany Duhart, who had informed her that she did not need to complete check and changes of the residents who are in hallway two, because Resident A was outside and there were no other residents in their bedrooms. Ms. Gilmer reported that she went to hallway one and completed checks and changes of those residents. Ms. Gilmer reported then all of a sudden, the assistant wellness director, Tyanna Stevenson, comes running out of her office saying that she did not see Resident A in her bedroom. Ms. Gilmer reported that's when they saw through the window that Resident A was outside on the patio on a chair, slumped over, Ms. Gilmer reported everyone went outside trying to check to see if Resident A was okay. Ms. Gilmer reported that Resident A was unresponsive, so staff Ms. Hunter called 911. Ms. Gilmer reported it was a Hospice nurse there for another resident who jumped in to assist until emergency medical services (EMS) arrived. Ms. Gilmer reported Resident A was transported to the hospital.

Ms. Gilmer reported she should not have been terminated because she did not falsify any records. Ms. Gilmer reported her belief that someone logged into the computer system under her credentials and documented that she had checked and changed Resident A. Ms. Gilmer reported she hopes that Resident A is doing well, and she hates that this happened.

On 08/11/22, I interviewed former staff Jacquline Hunter and she reported that she arrived at work at 3:00 p.m. on 07/19/22. Ms. Hunter reported she was never informed by Ms. Duhart or Ms. Jones that Resident A was outside. Ms. Hunter reported that when she arrived at work, she went into Ms. Stevenson's office and was speaking with her. Ms. Hunter reported shortly after she left out of Ms. Stevenson's office, she sees her come out and ask, "Where is Resident A?" Ms. Hunter reported that she thought Resident A was in her room because she was not in the common area. Ms. Hunter reported she checked her room, and she is not in there, and reported they saw her outside on the patio and observed that she was unconscious. Ms. Hunter reported she called 911 and while they were waiting on EMS to arrive a hospice nurse that was onsite for another resident, jumped in to assist them.

Ms. Hunter reported that she should not have been terminated because Resident A had been outside for at least 2 ½ hours prior to the start of her shift, and she was never told by Ms. Jones or Ms. Durhart that Resident A was outside. Ms. Hunter reported that she wants her job back because she the loves the residents and

enjoys being a caretaker. Ms. Hunter reported that she is sorry that this happened to Resident A, and she is praying that she makes a full recovery.

On 08/11/22, I interviewed Guardian (1) and he reported that when the incident occurred, he received a call from the facility informing him of what happened. Guardian (1) reported that prior to this incident he had not had any concerns regarding the care being provided. Guardian (1) reported that there were little things like Resident A missing clothes or things misplaced, but no concerns regarding Resident A's overall safety or care.

Guardian (1) reported that Resident A is living at his home and since the incident, she is not doing well. Guardian (1) reported Resident A has been placed on hospice, her overall health has declined, she can no longer walk, she is limited in her conversation, and is a different person altogether. Guardian (1) reported that because Resident A was outside for that length of time, with a sweatshirt and sweatpants on, she had blisters on the back of her neck and down the middle of her back. Guardian (1) reported that she barely made it out of the emergency room.

On 08/16/22, I conducted the exit conference with licensee designee, Catherine Reese, and informed her of the findings of the investigation and the specific rules cited. Ms. Reese reported an understanding of the rule violations and reported she would submit a corrective action plan to address each violation.

On 08/17/22, I called assistant wellness director, Tyanna Stevenson, and left a message requesting a return call.

APPLICABLE RULE	
R 400.15201	**Qualifications of administrator, direct care staff, licensee, and members of the household; provision of names of employee, volunteer, or member of the household on parole or probation or convicted of felony; food service staff.**
	(10) All members of the household, employees, and those volunteers who are under the direction of the licensee shall be suitable to assure the welfare of residents.

ANALYSIS:	Ms. Jones and Ms. Duhart were the initial staff on shift responsible for the care and welfare of Resident A. Ms. Jones took Resident A outside on an extremely hot day with a sweatshirt and sweatpants on. Ms. Jones and Ms. Duhart failed to check on Resident A frequently while she was outside, especially due the hot temperature (over 90 degrees), or make the decision, based on the temperature, not to honor her request to go outside. Ms. Jones and Ms. Durhart, further failed to adhere to their internal policy to check and change every resident every two hours, or more often if necessary. Ms. Hunter and Ms. Gilmore were the afternoon staff that arrived at 3:00 p.m. and 3:45 p.m. respectively, and also failed to adhere to their internal policy, and change of shift protocols, that require staff to check and change each resident at the start of their shift. Had they done so, they would have known that Resident A was not inside the facility. Resident A was left outside in the heat for nearly four hours, resulting in her losing consciousness and having to be hospitalized. Guardian (1) reported that due to this unfortunate incident Resident A is not the person she was prior. This violation is established as Ms. Jones, Ms. Duhart, Ms. Hunter and Ms. Gilmore are not suitable to assure the welfare of residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15303	**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:	Resident A was taken and left outside in over 90-degree weather for nearly four hours. Ms. Jones, Ms. Duhart, Ms. Hunter and Ms. Gilmore all failed to adhere to their internal policy, by failing to complete their required check and changes. This internal policy involved staff visually checking each resident and changing them if needed. Ms. Jones, Ms. Duhart, Ms. Hunter, and Ms. Gilmer also falsified records by inputting in their facility's database that they completed those checks. Ms. Molina and Ms. Reese reported if the required checks would have been completed, Resident A would have been found much earlier and would not have remained outside for the length of time she did. I reviewed Resident A assessment plan, the plan documents that Resident A should avoid extreme temperatures due to her risk of hypothermia and hyperthermia. This violation is established as the licensee failed to provide supervision, protection, and personal care as defined in the act and as specified in Resident A's assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

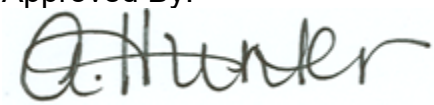
Contingent upon receipt of a corrective action plan, I recommend the status of the license remain unchanged.

08/18/22

Pandrea Robinson
Licensing Consultant

Date

Approved By:



08/22/22

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Ardra Hunter
Area Manager

Date